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ABSTRACT

This issue of "The Future of Children" focuses on efforts to provide publicly funded health insurance to low-income children in the United States through Medicaid and the State Children's Health Insurance Program (SCHIP). The articles summarize current knowledge and research about which children are uninsured and why, discuss ways to improve access to health care for special populations, explore aspects of designing and marketing public health insurance programs for children, and describe innovative strategies states have used to simplify enrollment and renewal procedures to help boost coverage. Following a statement of purpose for the volume, the articles are: (1) "Health Insurance for Children: Analysis and Recommendations" (Eugene M. Lewit, Courtney Bennett, and Richard E. Behrman); (2) "Historical Overview of Children's Health Care Coverage" (Cindy Mann, Diane Rowland, and Rachel Garfield); (3) "Which Children Are Still Uninsured and Why" (John Holahan, Lisa Dubay, and Genevieve M. Kenney); (4) "Enrolling Eligible Children and Keeping Them Enrolled" (Donna Cohen Ross and Ian T. Hill); (5) "Gaps in Coverage for Children in Immigrant Families" (Gabrielle Lessard and Leighton Ku); (6) "The Unique Health Care Needs of Adolescents" (Claire D. Brindis, Madlyn C. Morreale, and Abigail English); (7) "Care of Children with Special Health Care Needs" (Peter G. Szilagyi); (8) "Reducing Health Disparities among Children" (Dana C. Hughes and Sandy Ng); (9) "How Public Health Insurance Programs for Children Work" (Kirsten Wysen, Cynthia Pernice, and Trish Riley); (10) "Promoting Public Health Insurance Programs for Children" (Michael J. Perry); 11) "Balancing Efficiency and Equity in the Design of Coverage Expansions for Children" (Linda J. Blumberg); (12) "Premium Assistance" (Richard E. Curtis and Edward Neuschler); (13) "Express Lane Eligibility" (Dawn Horner, Wendy Lazarus, and Beth Morrow); (14) "Presumptive Eligibility" (Rachel Klein); and (15) "Universal Health Care for

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Children: Two Local Initiatives" (Liane A. Wong). All articles contain endnotes. The issue concludes with a glossary of selected terms and acronyms, and a 23-item bibliography. (KB)

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Health Insurance for Children

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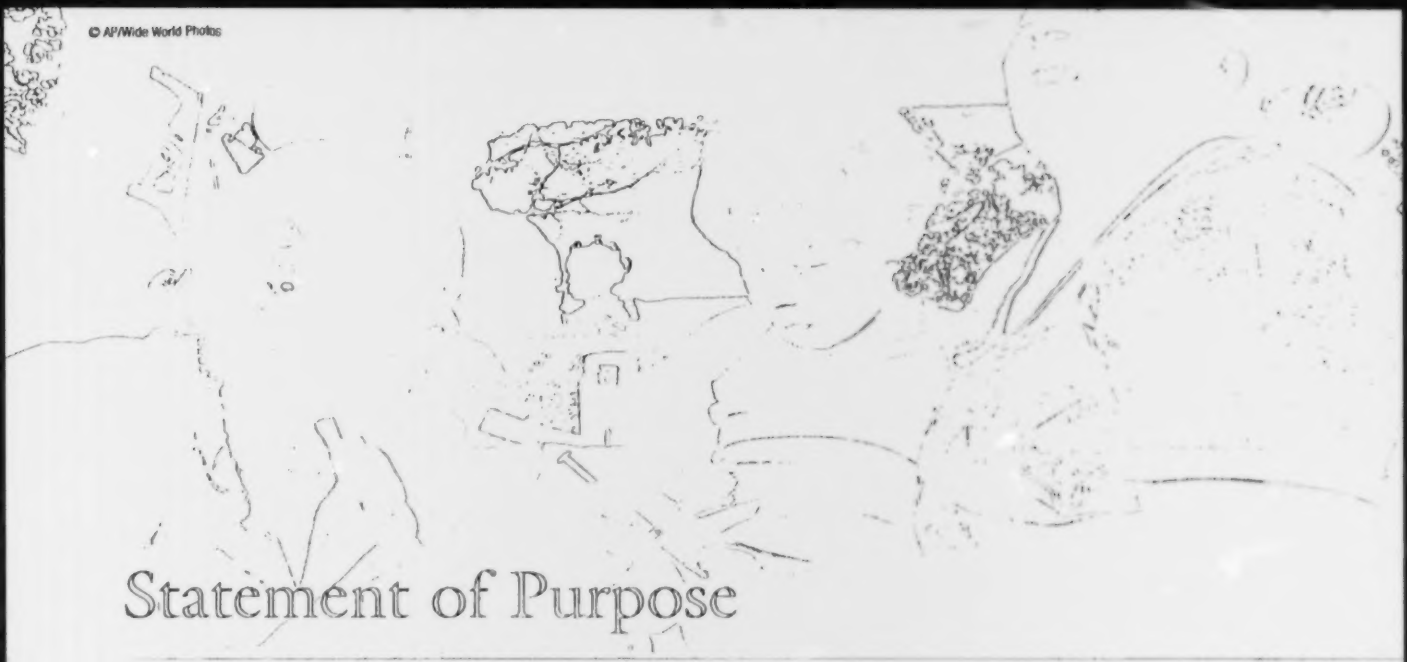

Statement of Purpose

The primary purpose of *The Future of Children* is to promote effective policies and programs for children. The journal is intended to provide policymakers, service providers, and the media with timely, objective information based on the best available research regarding major issues related to child well-being. It is designed to complement, not duplicate, the kind of technical analysis found in academic journals and the general coverage of children's issues by the popular press and special interest groups.

This issue of the journal focuses on efforts to provide publicly funded health insurance to low-income children in the United States through Medicaid and the State Children's Health Insurance Program (SCHIP). During the past four decades—beginning with Medicaid in 1965 and, more recently, with the creation of SCHIP in 1997—public health insurance coverage for children has evolved into a national policy priority. Together, these programs have made substantial progress in reducing the number of uninsured children. The articles in this issue summarize current knowledge and research about which children are uninsured and why, and describe the innovative strategies states have used to simplify enrollment and renewal procedures to help boost coverage.

The overarching message in this journal is a positive one: SCHIP and Medicaid work. Despite the documented success of Medicaid and SCHIP, however, high uninsurance rates among low-income children continue to be a complex problem, and a weak economy, rising health care costs, and funding shortfalls threaten to erode recent gains. To fulfill the promise of these programs, further progress is needed on several fronts. For example, these programs need to continue their focus on enrollment, outreach, and retention to ensure coverage for the high numbers of eligible yet uninsured children; they need to be supported by improved financing mechanisms; and they need to expand coverage to low-income children who are currently ineligible. If Medicaid and SCHIP could be extended to their full capacity and implemented properly, they could potentially cover virtually all low-income children in the United States.

We welcome your comments and suggestions regarding this issue of *The Future of Children*. Our intention is to encourage informed debate about the most effective strategies for providing publicly funded health coverage to low-income children. To this end we invite correspondence to the Editor-in-Chief. We would also appreciate your comments about the approach we have taken in presenting the focus topic and welcome your suggestions for future topics.

Richard E. Behrman, M.D.
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Health Insurance for Children: Analysis and Recommendations

Ten years ago, health insurance coverage for children in the United States appeared to be on the decline. At that time, in the first issue of *The Future of Children* that focused on health care, we observed that high and rising health care costs, an economic downturn, and concern that the "dynamics in the private health insurance market make continued coverage unpredictable" were all contributing to the public's dissatisfaction with the health care system.[1] The evidence presented in that journal issue suggested that children's health care was being adversely affected by the same forces buffeting the rest of the health care system. For example, one article reported that children were much more likely to lack health insurance in 1987 than in 1977 and that, over that same period, health care used by uninsured children declined relative to use by children with coverage.[2] As this issue goes to press, the economy is once again in a recession after years of strong growth, health care costs are rising rapidly again after several years of moderate growth, and the number of uninsured is growing. Unlike the situation a decade ago, however, the rate of uninsurance among children, which peaked in 1998 at 15.4%, has been declining recently, thanks to the expansion of public health insurance programs for children.

The national commitment to public health insurance programs for children has evolved over several decades, beginning in 1965 with Medicaid for poor children and culminating in 1997 with the enactment of the State Children's Health Insurance Program (SCHIP) for the uninsured children of working, low-income families. Nationally, almost two-thirds of all children are covered by employer-sponsored health plans offered to their parents in the workplace. Although many low-income children—children in families with incomes below 200% of the federal poverty level (FPL)—have access to employer-sponsored insurance through their parents, many parents cannot afford the premiums to cover the entire family. Other low-income parents work in low-paying jobs that do not offer health coverage, and these parents cannot afford to purchase insurance on their own. For the children of such parents, public coverage plays a critical role. In 2001, Medicaid and SCHIP provided coverage to approximately 24 million children (30% of all children and more than 40% of low-income children), and in 2002, federal and state funds of more than $40 billion were spent on health coverage for low-income children.[3]

The public investment in children's health insurance reflects both a national commitment to protect children's health and the social value that Americans place on children's well-being. Public-opinion surveys demonstrate broad public support for children's health insurance; and although many factors in children's physical and social environments influence their health and well-being, health insurance is an important tool that gives children access to crucial health services.

Despite the progress of recent years, high uninsurance rates among low-income children and families continue to be a difficult and complex policy problem, while state and federal budget deficits coupled with problems with the federal funding formula for SCHIP threaten to undo recent gains. Yet, the findings presented in this journal issue suggest that Medicaid and SCHIP have demonstrated their potential for improving the lives of America's most vulnerable children. If states and policymakers build on the success of existing programs, these programs could eradicate uninsurance among low-income children in the United States.

This journal issue addresses some of the most persistent questions related to publicly funded health insurance for children and synthesizes lessons learned about how to make these programs more responsive to the needs of low-income children. Among the questions addressed are: Which children are still uninsured and why? What are effective ways to enroll eligible children in public health insurance programs and keep them enrolled? How can public insurance programs better serve the needs of especially vulnerable children, including children with special health care needs, adolescents, and children in immigrant families? We also highlight some creative ways to insure more children.

This article frames some of these issues and draws on the most current research to point to solutions to persistent problems. The article begins by discussing the importance of health insurance for children's access to health care and describes the progress that has been made in providing coverage for children. The challenges in fulfilling the promise of public health insurance programs are discussed, as well as the steps to extend these programs and implement strategies to cover virtually all low-income children.

Health Insurance Matters

At the most basic level, both private and public health insurance coverage reduce the out-of-pocket costs of health care. As a result, children have greater access to health care services and reap the benefits of such services, and families are cushioned from the economic hardship that can accompany an illness or injury requiring medical care. In addition to the tangible benefits for children's health and families' economic well-being, health insurance coverage can reduce stress for parents who might otherwise be anxious or frightened about the prospect of rearing children without such insurance. Depending on the scope and depth of benefits offered, health insurance can facilitate access to care for acute and chronic illness, as well as access to preventive care. Improved access to effective health care can improve children's health status over time, which in turn may positively affect many other aspects of children's lives. In addition, by helping to underwrite the health care costs of serious illness, insurance reduces the risk that illness or injury will result in economic hardship, which may be especially catastrophic for families with limited means. Hughes and Ng relate in this issue that about 36% of families of children newly enrolled in public coverage reported that the lack of coverage had created financial difficulties for them prior to enrollment, and 74% of these parents reported being worried, scared, and stressed before their children had coverage.[4] By reducing the financial risks uninsured families face, insurance coverage for children can help reduce stress and improve a family's quality of life.

Benefits of Access to Health Care

Research demonstrates that health insurance—whether privately or publicly sponsored—is positively associated with key indicators of children's use of health services.[5] In comparison to their uninsured peers, children who are insured are more likely to have a regular source of medical care and to receive health care when they need it, and they visit health care practitioners more often.

For instance, a recent study that looked at patterns of health care use among children who were enrolled in SCHIP and those who were uninsured found that children covered under SCHIP were more likely than their uninsured peers to have well-child care, dental and specialty visits, and recommended immunizations.[6] The same study also looked at use patterns among children before and during enrollment in SCHIP and found that children had more outpatient visits and were more likely to have a well-child care visit after they enrolled.

Increased access to health care services also helps ensure that children get the health services they need. For example, insured children consistently have fewer unmet health care needs than their uninsured peers. In a study that examined levels of unmet need for medical care, dental care, and prescription drugs among the same group of

children before and after they enrolled in SCHIP, levels of unmet need decreased in all categories after enrollment in the public insurance program.[7] A study that compared low-income children with Medicaid coverage and those without insurance found that children with Medicaid coverage were less likely to have unmet or delayed needs for prescription drugs and for medical, surgical, and dental care.[8] In contrast, uninsured children are more likely to have health problems that routine health care could either prevent or help to manage,[9] and they often fail to receive prescribed medications because of cost.[10]

Insurance is also a powerful predictor of whether a child has a regular source of health care.[11] Overall, having a regular source of care, particularly primary care, encourages the use of health services and increases the benefits of services received.[12] As Hughes and Ng note in their article, children who have a regular source of care are more likely to receive needed immunizations and have annual preventive care visits. Their families also report higher levels of satisfaction with their health care.[13] Furthermore, there is evidence that when children develop long-term relationships with a particular health care provider, they may receive more accurate diagnoses, require fewer hospitalizations, and incur lower health care costs.[14]

Of course, health insurance alone cannot be expected to always improve health status; too many other factors are important. Nonetheless, some studies suggest that health insurance can play a very important role. For example, several studies suggest that on select measures, the health of children improves with insurance. A recent evaluation of California's SCHIP program, Healthy Families, indicated that children who started the program with the poorest parent-reported health status enjoyed dramatic improvements in health after one year in the program, whereas children who started the program in relatively good health maintained their health status.[15] In another study, parents of children with asthma reported improvements in their children's health after enrollment in New York's Child Health Plus program.[16]

Other Factors Affecting Health Status and Access to Care

As mentioned above, children's health status is shaped by a number of factors, many of which—culture, environment, socioeconomic status, geographic location—are not influenced by access to health care.[17] Furthermore, the benefits of health care are bounded at any point in time by limits on scientific knowledge and technical capacity. Thus, although increasing health insurance coverage may improve children's health, Hughes and Ng caution that it is only one of many issues that must be considered to promote children's health. The larger social and environmental context that shapes children's health also needs to be addressed to improve health outcomes for disadvantaged children.

Even families with health coverage may face barriers to receiving care, such as the difficulty of finding a health care provider who is conveniently located, with hours that can accommodate a family's work and child care schedules. Families may also find it difficult to find providers with the linguistic skills and cultural sensitivity necessary to provide quality care. The low reimbursement rates and the administrative burdens placed on providers by some public insurance programs make many providers reluctant to participate, resulting in additional access problems for families and children. These issues will need to be addressed if public health insurance programs are to reach their full potential to meet children's needs.

Current Progress in Expanding Public Coverage for Children

Although the creation of SCHIP may have motivated the most recent growth in coverage for children, Mann and colleagues note in this journal issue that public health insurance for children has a long history. The authors trace current programs back to the maternal and child health programs of the Depression Era, including grants to the states for maternal and child welfare through the Social Security Act of 1935 and cash assistance through the Aid to Families with Dependent Children (AFDC) welfare program. The next significant milestone was the 1965 enactment of Medicaid, which provided medical assistance to families who were receiving welfare—primarily unemployed single mothers and their children under age 18. Medicaid also provides coverage for low-income seniors and people with disabilities. The program is structured as a joint federal–state program.[18] States administer the program, making specific decisions about eligibility and benefits within broad

guidelines set by the federal government. The federal government in turn provides matching funds, or payments to the states for some (about 57% on average) of the costs involved with providing health services to Medicaid beneficiaries.[19]

A series of expansions (known as the poverty-related expansions) to the Medicaid program began in the mid-1980s and provided the building blocks for SCHIP. For example, the link between welfare receipt and participation in Medicaid was weakened to allow states to cover children in low-income families who were not receiving cash assistance. This change substantially increased Medicaid enrollment of children in the late 1980s and early 1990s.

When Congress reformed welfare in 1996, the Personal Responsibility Work and Opportunity Reconciliation Act (PRWORA) completed the delinking of Medicaid eligibility and the receipt of cash assistance that had begun years earlier.[20] As a result, eligibility for Medicaid is now determined by a family's income and other resources, not by its status as a welfare recipient. Severing the link between Medicaid and welfare has had its advantages as well as disadvantages. On the one hand, the stigma associated with public benefit programs may have deterred some eligible families from taking advantage of Medicaid.[21] On the other hand, the welfare system did provide a comprehensive intake process that helped some needy, low-income, female-headed families receive a variety of public supports, including Medicaid. Following enactment of PRWORA, children's enrollment in Medicaid declined, but it has recovered in recent years.[22]

Following a failed attempt by the Clinton administration to institute comprehensive health reform in the mid-1990s, the political momentum around health care focused toward incrementally broadening coverage for children. The result was SCHIP, which was enacted in 1997 through Title XXI of the Social Security Act. Building on the framework provided by Medicaid, SCHIP was intended to provide insurance for low-income, working families who earned too much to qualify for Medicaid, but did not have private coverage. Funded through a federal block grant, the program gave states more flexibility than Medicaid offered to experiment with a variety of approaches to expanding coverage for low-income, uninsured children.[23] For example, states have the option to simply expand eligibility for health coverage under an existing Medicaid plan (Medicaid expansion SCHIP), create a separate SCHIP program, or use a combination of both approaches.

Although Medicaid is targeted to children in families with very low incomes, while SCHIP targets children in higher-income (yet still low-income) families, the two programs have evolved to be interdependent and complementary in a number of areas. (The interdependence between the programs may be beneficial for children, as recent research indicates that many children move back and forth between the two programs as family income changes.) Federal law links the two programs by requiring that children who apply for health coverage under separate SCHIP programs be screened for Medicaid eligibility as well and enrolled in the program for which they qualify.[24] In addition, Wysen and colleagues note that during SCHIP's initial implementation phase (from 1998 to 2000), the program benefitted from the extensive infrastructure for providing access to health services that state Medicaid programs had developed. Several separate SCHIP programs contracted with health plans their states' Medicaid programs used, and they used similar quality-assurance techniques.[25] In turn, SCHIP influenced Medicaid enrollment procedures and systems, making it easier for eligible children to enroll in both programs. Nonetheless, the potential still exists to further align and coordinate the two programs in order to serve children more effectively.

The past decade has brought progress in improving children's access to health care on several important fronts, including reductions in the numbers of children without health coverage, systems that streamline and align enrollment and renewal in public health insurance programs, and the provision of comprehensive health benefits to needy children. In addition, for the first time, public health insurance programs actively worked to enroll eligible children and designed promotional campaigns to encourage families to participate.

Reducing Uninsurance Rates among Children

Between 1998 and 2002, the number of children in the United States who lacked health coverage declined by approximately 2.6% (1.7 million children).[26] After SCHIP was launched in 1997, health coverage for chil-

dren in families between 100% and 200% of the FPL, SCHIP's primary target group, increased markedly.[27] Holahan and colleagues note in this issue that in addition to the expansions in public coverage for children that occurred from 1994 to 2000, a robust economy helped drive down uninsurance rates for children by increasing their families' access to employment-sponsored coverage.

By 2001, Medicaid was providing health coverage to 21 million low-income children, and SCHIP to nearly 3.5 million low-income children.[28] These programs now serve as the primary source of coverage for children from low-income families (those with incomes below 200% of the FPL, or $36,200 for a family of four in 2002).[29]

Simplifying Enrollment

The attention paid to outreach and simplifying enrollment in the SCHIP program has been unusual for public benefit programs, which frequently strive to limit access and restrain usage. SCHIP is designed to reach children in low-income, working families, some of whom may have little experience with public benefits. The program's success, which has been measured by how effectively it reaches its enrollment targets, rests on its ability to find and appeal to such families, and program administrators have invested funds and energy in marketing and in streamlining procedures and systems to make programs more attractive.

These SCHIP innovations have subsequently influenced Medicaid. Because of its historical link to welfare, Medicaid's application and enrollment procedures once reflected welfare application procedures: long, complicated forms that needed to be completed in a welfare office; face-to-face interviews that included intrusive questions; and onerous documentation and filing requirements. In the mid-1990s, before SCHIP was created, states started simplifying Medicaid enrollment procedures for children, eliminating asset tests and face-to-face interview requirements and allowing families to apply at some hospitals and clinics rather than welfare offices. SCHIP greatly accelerated this simplification process, and by January 2002, most states had adopted key simplification strategies, which are described in the articles by Cohen Ross and Hill and by Wysen and colleagues.[30]

Providing Comprehensive Health Benefits

The benefit packages under SCHIP and Medicaid in most instances are more generous than those typically offered under private plans.[31] The benefits children receive under Medicaid, for example, are considered particularly comprehensive. Most significant for children was the 1967 creation of the Early Periodic Screening, Diagnosis, and Treatment program (EPSDT) as a component of Medicaid.[32] EPSDT provides comprehensive screenings—such as vision, dental, and hearing screenings—as well as diagnostic and treatment services. As Mann and colleagues explain, the EPSDT program extended Medicaid's role from simply paying for health services to actively trying to ensure that children receive comprehensive preventive care and treatment with regular health screenings, physician and hospital visits, well-child care, and vision and dental care. Although Medicaid benefits vary by state, they tend to cover more services than are typical under private health insurance or SCHIP.[33] In addition, unlike families with private health coverage, and to a lesser extent SCHIP, families usually do not have to contribute financially toward the care of children covered under Medicaid (cost sharing).

SCHIP's benefits are designed to be more comprehensive than private coverage, but they tend to be less comprehensive than Medicaid's.[34] For example, SCHIP benefits include physician, hospital, well-baby and well-child care, prescription drugs, and limited behavioral and personal care services, but not the comprehensive screenings provided under EPSDT. In addition, separate SCHIP programs usually require families to pay premiums and contribute toward the cost of health care that their children receive under the programs, although federal law prohibits these costs from exceeding 5% of a family's annual income.[35]

Fulfilling the Promise

Medicaid and SCHIP, aided by a strong economy, have made substantial progress in expanding health coverage to low-income children. However, as many as 9 million American children still lack health insurance. If the problem of uninsured children in the United States is to be solved—and public-opinion surveys document that 85% to 90% of Americans think it should be—public health insurance programs have

been demonstrated to be an effective vehicle for providing health coverage to children. Indeed, data presented in the article by Holahan and colleagues in this journal issue demonstrate the potential of these programs, when implemented effectively, to provide health coverage to almost all uninsured children nationwide (see Table 1). Most important to reducing the uninsurance problem facing children is raising participation in Medicaid and SCHIP, as 76% of uninsured children are already eligible for coverage under SCHIP and Medicaid, but are not enrolled.[36] A continued focus on simple and convenient enrollment and renewal systems, as well as proactive outreach and educational efforts, will be key to reaching these children. Special efforts will be needed to enroll Latino and other minority children, children in immigrant families (families in which at least one member is an immigrant), and adolescents. Children in these groups are all overrepresented in the ranks of the eligible, but uninsured.

In addition, 6% of uninsured children are undocumented immigrants who would meet the income eligibility levels for Medicaid and SCHIP. Expanding these programs to cover this population of children and restoring legal immigrant children's eligibility for federal Medicaid and SCHIP funds (repealed in 1996) would not only reduce the number of uninsured children directly, but could have an important positive impact on the large population of currently eligible but unenrolled children in immigrant families. Lastly, expanding SCHIP eligibility to uninsured children in families with incomes below 300% of the FPL, as several states have done, with adequate provisions to minimize the substitution of public coverage for privately financed coverage (crowd-out) could provide coverage for another 5% of uninsured children. Building on the current

Table 1

The Potential of Medicaid and SCHIP to Reduce the Number of Uninsured Children in the United States

Category	Percent of Uninsured Children	Number of Children (in millions)	Annual Cost of Coverage[a]	
			States Share (in billions)	Federal Share (in billions)
Currently Eligible for Medicaid	51%	4.69	$2.9	$3.8
Currently Eligible for SCHIP	25%	2.30	$0.8	$2.2
Undocumented Low-Income Immigrant Children	6%	0.55	$0.5	$0.7
Uninsured Children Made Eligible by Expanding SCHIP Coverage to 300% of the FPL	5%	0.46	$0.2	$0.4
Total Children and Costs Associated with Use of Existing Programs to Cover Uninsured Children Up to 300% of the FPL[b]	87%	8.00	$4.3	$7.1
Uninsured Children in Families with Incomes above 300% of the FPL[c]	13%	1.2	–	–

[a]Assumptions in calculations: average annual cost per enrollee—$1,431 in Medicaid and $1,273 in SCHIP; federal matching rates—Medicaid 57% and SCHIP 74%; undocumented children eligible for Medicaid and SCHIP in the same ratio as eligible unenrolled children.

[b]Totals may not equal 100%, due to rounding.

[c]These children constitute less than 2% of all children in the United States.

Sources: Cost data from Holahan, J., and Kenney, G. Urban Institute, based on March 2002 Congressional Budget Office estimates. See also the article by Holahan and colleagues in this journal issue.

system of public and private coverage for children, these additional strategies could leave only about 3% of all children without health insurance.

Currently, however, the progress of recent years, let alone the promise of these additional steps, is threatened by massive budget shortfalls in most states, a growing federal deficit, and an economic slowdown and rising health care costs, which are eroding private health care coverage. In such a fiscal environment, suggesting even modest expansions of coverage may appear audacious, yet as indicated in Table 1, the marginal cost of covering immigrant children and uninsured children up to 300% of the FPL is small relative to the amount that is already being spent to cover currently eligible children ($44 billion) and the amount that will be needed to provide coverage for currently eligible children who are not enrolled in public insurance programs. In any case, to fulfill the promise of the current Medicaid and SCHIP programs, the current federal–state funding systems for these programs will need to be stabilized, enhanced, and better coordinated with the private insurance system.

Because fiscal conditions appear to be so critical to fulfilling the promise of children's public health insurance programs, reforming program financing is the focus of the next section. We then turn our attention to program operations in the areas of outreach, enrollment, and retention; the needs of especially vulnerable populations; and lastly, program expansions.

Financing Public Health Insurance Programs

The rapid growth in public health insurance programs combined with the economic slowdown has surfaced several problems with the federal–state financing systems for Medicaid and SCHIP. Several of these issues, including the need for more money for public health insurance programs during recessions, when tax revenues are down, idiosyncrasies in the financing system for SCHIP, and unequal federal cost-sharing rates for SCHIP and Medicaid, are discussed in this section. In addition, the potentially cost-saving strategy of extending public coverage by using public funds to subsidize employment-based coverage is explored.

Counter-Cyclical Financing

For the first time since SCHIP was created, public health insurance programs are struggling to maintain the status quo in the face of rising health care costs, state and federal budget deficits, a weak economy, and a rising number of unemployed and uninsured families.

The demand for public health insurance increases during hard economic times because as unemployment rises, families lose access to employer-sponsored coverage. Approximately 1.4 million Americans lost their health insurance in 2001,[37] and a recent study found that an increase in the unemployment rate of 1% would increase Medicaid enrollment by more than 1.5 million persons, including 1 million children.[38] The overall cost to the Medicaid program of this increase in enrollment was estimated at almost $3 billion, including $1.2 billion to be borne by states. In addition, health care costs have begun to increase rapidly after several years of relative stability. This acceleration in the costs of health care has increased the cost of employer-sponsored coverage, reducing the number of companies that offer employment-based health coverage. Many employers that do offer coverage are asking employees to pay a higher portion of the cost of coverage, leading some employees to drop coverage (particularly dependent coverage, which is less heavily subsidized by employers than coverage for the employee alone).

A slowdown in the economy and an increase in unemployment also impact state and federal revenues. As a result, states and the federal government are struggling with growing budget deficits. States are also feeling the pressure from increased health care costs. Medicaid spending, which makes up more than 20% of all state budgets, is outpacing total state revenue growth. Second only to education in most state budgets, spending on Medicaid, fueled primarily by increases in costs for the elderly and disabled, has grown by 25% over the last two years.[39] States have a limited number of strategies to control program costs. They can reduce program enrollment, reduce benefits, increase cost sharing (premiums, co-payments, and so forth), or reduce payments to providers. All will reduce access to health care. To date, states have applied these options primarily to Medicaid programs for adults, but as states' fiscal crises deepen, there are increasing reports of plans to apply these cost-cutting measures to programs for children as well.

Governors are projecting revenue shortfalls of $30 billion in 2003, and as much as $80 billion in 2004.[40] Fur-

thermore, all states but one (Vermont) are required to balance their budgets each year,[41] which means they must either raise taxes or cut spending on social programs. The federal government also operated with a deficit in 2002 and has a projected deficit close to $200 billion in 2003.[42] Unlike states, however, the federal government can operate with a budget deficit, which gives it more flexibility to contribute to safety net programs during hard economic times.

To cope with the increased need for public health insurance programs during economic downturns and budget crises, state and federal governments would be wise to develop a counter-cyclical financing system that ensures funding for public programs during recessions, when demand for the programs increases. (Although many states have so-called rainy day funds to help cope with revenue shortfalls, these funds do not appear to be adequate to also accommodate the increase in demand for public health insurance coverage that accompanies economic slowdowns.) A possible model for public health insurance programs to follow is the funding system for unemployment insurance. The state and federal governments have established unemployment insurance trust fund accounts for each state that is funded by a payroll tax. When employment is high, the trust fund is built up. When employment is low, the trust fund is drawn down to pay unemployment claims. The federal government can also contribute additional money into the trust fund during difficult times to extend unemployment benefits, as the Bush administration has proposed to do in 2003. A similar counter-cyclical funding system would help ensure adequate funding for SCHIP and Medicaid when demand for the programs increases during difficult economic times.

Another strategy would be to temporarily increase the federal government's contribution (the federal matching rate) for SCHIP and Medicaid to help states during economic downturns. Legislation to temporarily increase the federal matching rate for Medicaid and also to provide additional fiscal relief for states via federal block grants was introduced in Congress in 2002, but it did not pass. This suggests the need for a more reliable mechanism, such as a specific set of criteria (state revenues dropping below a certain level or an increase in unemployment by a specified amount) to trigger increases in the matching rate and to help states avoid program cuts during recessions.

RECOMMENDATION: Counter-Cyclical Financing

State and federal governments should create a financing system that increases funds for Medicaid and SCHIP to meet the increased demand for public health insurance during economic downturns.

Problems with SCHIP Funding

SCHIP also faces several major federal funding problems unrelated to states' current budget problems. These problems are by-products of the way that Congress scheduled the distribution of federal funds to the states for SCHIP. SCHIP was funded as a block grant to states, providing them with $40 billion over 10 years. Yet, the money was not distributed evenly over the 10 years. Instead, Congress allocated more money for the first 4 and last 3 years of the program than for the middle years in order to meet balanced-budget targets. As a result, federal funding for SCHIP decreases by more than $1 billion in each fiscal year from 2002 to 2004. This decrease (the "SCHIP dip") unfortunately coincides with an increased need for SCHIP funds because of steadily increasing enrollment.

In addition, almost $3 billion of unspent federal SCHIP funds are scheduled to "expire" and return to the U.S. Treasury at the end of 2002 and 2003.[43] These funds will expire because they were not used within the time period established by the SCHIP statute. Although SCHIP (like all new public programs) needed time to establish itself and to meet federal budgeting requirements, Congress allocated more funding to the states in each of the first four years of the program than for any of the next five years. States were allowed to carry forward their unspent federal SCHIP allotments for three years, however, to smooth out the federal funding stream and to fund program growth. Many states have not yet used up all their allotment carry forwards, and although Congress enacted a temporary fix in 2000—reallocating and extending the timeline for use of unspent funds—these funds will revert to the Treasury unless their availability is extended again.

Finally, the allocation formula specified in the statute has resulted in many states receiving more federal funding than they need, while other states may soon use up their initial federal SCHIP allotments.[44] The SCHIP statute provides for unspent funds to be reallocated after three years from the states with unspent allotments to those that have fully spent their federal funds. This reallocation process has been only a limited success, however, with some states having to return their unspent allotment to the Treasury, while others are considering capping their program enrollments when their federal funds are used up.

The net result of these funding quirks is that SCHIP enrollment may slow or even fall (about one-quarter, 900,000, of the children now served by SCHIP may lose their coverage) because 17 states may not have sufficient federal funding to sustain their SCHIP programs between 2003 and 2007.[45] (Because of the SCHIP dip and the expiration of funds, states will have about $6 billion less in federal funding for SCHIP over this four-year period.[46]) Without adequate funding, the program will not be able to provide coverage for children as was intended; and without changing the way funding is allocated among states, states that have fully used their SCHIP funds will not receive additional money to continue to build their programs and may even be unable to avoid having to reduce the number of children they insure.

Legislation to address some of these SCHIP funding problems was introduced in the Senate in 2002 and again this year, and the National Governors' Association and others have proposed remedies for SCHIP's funding problems. But to date, nothing has passed, and $1.2 billion in unspent federal SCHIP funding reverted to the Treasury at the end of Fiscal Year 2002.[47]

RECOMMENDATION: SCHIP Funding

The federal government and states should work together to resolve the funding problems in SCHIP to ensure stable and adequate federal funding for SCHIP in all states.

Discrepancies in the Federal Matching Rate

The federal matching rate refers to the percentage of program costs that the federal government provides to states for their Medicaid and SCHIP programs. This rate, which depends on a number of factors, varies among states and over time. In general, the federal matching rate is higher in states that have fewer resources per person than in wealthier states.

Yet, while Medicaid covers many more children than SCHIP and targets children in families with lower incomes than those covered under SCHIP, the federal matching rate for SCHIP is on average 30% higher than the rate for Medicaid.[48] As a result, the federal government currently pays about 57% of Medicaid program costs and 74% of SCHIP costs,[49] which means that states have to use more of their own money to cover children who are eligible for Medicaid than to cover children in SCHIP. This provides states with a financial incentive to enroll children in SCHIP rather than Medicaid because states can use fewer state dollars per SCHIP enrollee.

Raising the federal matching rate for children enrolled in Medicaid to the same level as the SCHIP rate would help states deal with their current financial crises and would be good policy for children for several reasons. First, Medicaid serves the bulk of low-income, uninsured children and is designed for the very disadvantaged, those who need public coverage the most. One out of every five children nationwide receives health coverage under Medicaid.[50] Medicaid pays for 30% of all pediatrician visits,[51] 38% of child hospitalizations,[52] and 40% of all U.S. births.[53] Raising the federal Medicaid matching rate would make it easier for states to maintain and improve the quality and integrity of their children's Medicaid programs. In addition, because more than one-half of uninsured children are in fact eligible for Medicaid, raising the matching rate would reduce the cost to states of enrolling these uninsured children, increasing the likelihood that states will move more aggressively to reach and enroll these children. Also, because the federal government can run a budget deficit while states cannot, Congress might consider raising the matching rate to help states serve vulnerable children during difficult economic times, when demand for public health coverage increases. Finally, many children currently move back and forth between SCHIP and Medicaid as their families' economic circumstances change or they age. Using the SCHIP matching

rate for both programs would simplify administration and reduce the need for certain program eligibility rules and procedures that can act as barriers to enrolling children in either program.[54]

The risk, however, particularly in challenging fiscal environments, is that states will use the additional funds provided by an increased federal Medicaid match for other programs. Therefore, it may be appropriate to tie any increase in the Medicaid matching rate to a requirement that states maintain most or all of their funding commitments to their children's Medicaid programs. This would create an incentive for states to expand program enrollment or improve their programs in other ways, such as by enriching benefit packages or increasing reimbursement for providers.

RECOMMENDATION: Federal Matching Rates

The federal government should raise the federal Medicaid matching rate for children to the same level as the SCHIP matching rate to encourage states to enroll more children in Medicaid, to provide states with fiscal relief, and to simplify administration.

Coordinating with Employer-Sponsored Coverage

Cost remains a barrier to expanding public health coverage for children, especially in difficult economic times. One potentially cost-effective avenue for expanding health coverage to children and families is to use public funds to subsidize private group health insurance offered through employers. This approach is practical because, although many uninsured poor children have parents who work at jobs that do not offer health coverage, 40% to 50% of uninsured children in families with incomes between 133% and 250% of the FPL have access to employer-sponsored coverage. In addition, the business community supports health coverage for children: 9 out of 10 employers nationwide reported concerns about uninsured children and their belief that every child should have some basic level of health care.[55]

Both SCHIP and Medicaid already authorize the use of public funds to help eligible low-income families pay the premiums for employer-based coverage. Curtis and Neuschler in this journal issue describe a strategy called premium assistance that uses public funds to enroll eligible children in their parents' employer-sponsored coverage. Premium assistance offers the potential for cost savings because employers usually cover most (70% to 75%) of the costs involved with providing family coverage.[56] For example, Rhode Island saves an average of $178 per month for each family enrolled in its premium-assistance Medicaid program rather than its straight Medicaid program.[57] Moreover, through premium-assistance programs, states can frequently insure entire families for less than the cost of enrolling eligible children in Medicaid or SCHIP. Children benefit when their parents have health coverage, and many parents prefer to have all family members in the same health plan.

As Curtis and Neuschler note, although a number of states have attempted to launch premium-assistance programs, progress has been slow, in part because of administrative rules under SCHIP intended to protect children from the limited benefit packages and families from the potentially burdensome cost sharing found in some private insurance plans. Recently, waivers have been granted to several states to relax some of these restrictions on the condition that families can choose to enroll their children in either the "regular" SCHIP program or an employer-sponsored plan and can switch to the purely public plan if they find that the employer-sponsored plan does not meet their needs.[58]

RECOMMENDATION: Coordination with Private Coverage

States and the federal government should cooperate in developing cost-effective health coverage for low-income children and their families by coordinating public health insurance programs with private, employer-sponsored coverage.

Addressing Barriers to Outreach, Enrollment, and Retention

Because the Medicaid and SCHIP programs have tremendous potential to address the problem of uninsured children, understanding and addressing the factors

associated with children's participation or lack of participation in these programs is key to solving the problem. Program policies and administrative practices, lack of knowledge about program availability, and not wanting or needing coverage have been identified as the main impediments to participation (see the article by Holahan and colleagues in this journal issue). Accordingly, simplifying program rules and administrative practices associated with both enrollment and retention, and educating parents about the availability and value of coverage (outreach activities), can lead to significant reductions in the ranks of uninsured children. (See the article by Wong in this journal issue for a discussion of innovative approaches to reducing uninsurance among children.)

Understanding the Causes and Consequences

Before modifying program practices and procedures, it is important to consider why these practices exist. Many program requirements and administrative procedures were established to ensure program integrity—that is, to make sure that the programs serve only the children they were intended to serve. For instance, documentation of income requirements helps to assure that only children in families with incomes that qualify them for public health coverage receive it. (In this issue, Blumberg discusses the challenges of targeting coverage to specific populations while ensuring that a wide range of children are served.) The downside of using daunting administrative procedures (extensive documentation requirements, long detailed application forms, in-person interview requirements, frequent reporting, or reenrollment requirements) to ensure program integrity is that they can discourage even eligible families from participating in important programs.

A solution, however, lies in the definition of "program integrity." If a more comprehensive definition were used, one that includes how well a program serves its eligible population as well as how effectively it screens out the ineligible, the states could focus on balancing the impacts of exclusionary requirements against the imperative to serve targeted populations. Ultimately, decisions as to which administrative practices should be retained can be based on empirical research on the impact on program integrity of different policies and procedures, and agreement among stakeholders on what are acceptable tradeoffs between enrolling eligible and excluding ineligible children and families.

Unfortunately, there has been little research on the impact of different administrative procedures on program integrity. There is, however, much anecdotal evidence (as documented by Cohen Ross and Hill in this issue) of the positive effect on program participation of administrative simplification and of a change in the relative values assigned to enrolling versus excluding children from public health insurance programs that accompanied the rollout of the SCHIP program beginning in 1998.

Specifically, when Medicaid was viewed as a welfare program tied to cash assistance, it included many administrative rules, practices, and procedures to discourage participation. With the advent of SCHIP and federal welfare reform, however, the reframing of the children's Medicaid program as a health insurance program, and a shift in policy focus to reducing the number of uninsured children, many of the administrative barriers to children's participation in Medicaid were reduced or eliminated.

At the same time, in some states vestiges of the old restrictive Medicaid system remain, which means that the system that serves the poorest children still has more enrollment barriers than does SCHIP. For example, as of January 2002, four states required face-to-face interviews for enrollment into their children's Medicaid programs; only one state required these interviews for its SCHIP program as well. Four states also maintained an asset test (families need to document their assets on the application for benefits and are not eligible if their assets exceed a certain level) in their Medicaid programs, whereas only one SCHIP program had an asset test. In addition, many states that cover low-income parents as well as children in their Medicaid programs impose more enrollment requirements on adult family members than on children, with the result that it is more difficult for children to enroll as part of a family than as individuals. This complicates matters for parents and runs counter to parents' preference to enroll the entire family in a single insurance program.

The good news, however, is that most states have greatly improved their enrollment procedures in recent years (38 states required face-to-face interviews in 1997), and states are gradually adopting other procedures to simplify enrollment and retention processes. For example, 13 states do not require families to provide verification of the income they report on their applications. This system greatly reduces the paperwork burden on families. These

states now verify income and other information by matching identifying information provided by the family with existing state databases. Some states that have adopted self-declaration report a substantial reduction in application-processing time and costs while maintaining high levels of accuracy.[59] Other studies have documented administrative cost savings from other administrative simplifications. Because effective simplification strategies increase enrollment in health insurance programs, however, they are not likely to reduce overall program costs. Nonetheless, reducing administrative costs can free up resources for delivery of health care services to enrollees.

There is a danger that in the current fiscal environment, states will undo some of the administrative simplifications adopted in recent years in order to reduce program participation and program costs. For example, in 2001 Kentucky rescinded its policy that allowed self-declaration of income on children's health insurance applications, and it is considering reinstatement of face-to-face interview requirements at initial enrollment.[60] Using administrative procedures to reduce enrollments and public expenditures on coverage for children runs counter to the purpose of the programs.

Improving the Alignment of SCHIP and Medicaid

Further efforts can be made to streamline and simplify enrollment. One key area requiring further work, for example, is the need to improve the alignment of rules and procedures between Medicaid and SCHIP. Thirty-five states offer both Medicaid and separate SCHIP programs for low-income children. Yet, the interdependent and complementary relationship of Medicaid and SCHIP means that children move from one program to another as their family circumstances change or as they age. Aligning the programs and simplifying procedures that allow children to move between the programs would make the programs easier for families to navigate and would enable children to receive care more efficiently.

Thirty-three of the states that have separate SCHIP programs allow families to use a single form to apply for both Medicaid and SCHIP for their children, but many programs maintain program and procedural characteristics that create hurdles for families. Families may even have some children eligible for Medicaid and others eligible for SCHIP, so the families must comply with different sets of reporting requirements, deadlines, and procedures to provide health coverage for all their children.[61] Twenty states, however, have enacted uniform eligibility criteria for all children in a single family.

Programs can also be more responsive to changes in family circumstances by making it easier for children in families experiencing financial hardship to transfer from a separate SCHIP program into a Medicaid program (as most Medicaid programs do not require a financial contribution, whereas some SCHIP programs do). States can facilitate transfers by using a joint renewal application and establishing systems for sharing relevant information about children participating in both programs.[62] For example, Florida and Texas transfer applications electronically, whereas Kansas and New Jersey coordinate among eligibility workers to determine children's eligibility for either program. Other states with separate programs have facilitated enrollment and maximized administrative efficiency by using similar methods to determine eligibility and similar enrollment procedures, and by allowing one worker to determine eligibility for both programs.

Making Renewal as Easy as Possible

Enrolling eligible children in public coverage programs is only the first step toward ensuring their access to health care; keeping children enrolled presents an ongoing challenge. Many studies have demonstrated that eligible children are at risk for losing coverage at any time, but that the probability of disenrollment is highest when children must renew their coverage. Both SCHIP and Medicaid have encountered the problem of "churning," in which children lose coverage but reenroll within a few months. Other children bounce between Medicaid, SCHIP, and private coverage. An unknown number may experience protracted periods of uninsurance after disenrollment. In response, states have adopted a variety of approaches for simplifying renewal policies and procedures, as outlined below and discussed in the article by Cohen Ross and Hill.

For example, a growing number of states allow families to renew coverage for their children at longer intervals (such as every 12 months rather than every 6) or allow children to retain their public coverage for a full year even if their family income changes.[63] Twenty-one states are using joint renewal forms for Medicaid and SCHIP, which are helpful to families who have children in different programs or whose changed circumstances have

shifted their eligibility from one program to the other. Some states provide families with preprinted renewal forms and ask them to provide updates at renewal only on information that has changed. States are also experimenting with different methods for following up with families, such as phone calls, to remind them to reenroll their children. Florida uses a method called automatic or passive reenrollment in its SCHIP program. This procedure allows children to remain enrolled as long as families do not notify the program that their circumstances have changed, but continue to pay the program premiums. A recently published study found that although other states experienced 30% to 50% drops in enrollment at renewal in the absence of premiums, Florida's disenrollment at renewal was only 5%.[64]

RECOMMENDATION: Streamlined Procedures

States should make application, enrollment, and renewal procedures for Medicaid and SCHIP as easy as possible and should ensure that rules designed to maintain program integrity do not deter participation by eligible children.

Innovative Measures to Facilitate Enrollment

Two promising measures for streamlining enrollment, highlighted in this journal issue in articles by Klein and by Horner and colleagues, respectively, are presumptive eligibility and coordination with other public programs for children. A small number of states have used these strategies to ensure that eligible children receive coverage as quickly as possible and to create partnerships with other public programs that target children in low-income families.

Presumptive Eligibility

Presumptive eligibility allows entities such as health care providers and schools to immediately, but temporarily, enroll children who appear eligible into public health insurance programs. While their families complete the application process, the children will receive health care services for which providers are reimbursed, even if a child is ultimately found to be ineligible.[65] As of August 2002, 10 states had adopted presumptive eligibility under Medicaid, and 5 states had adopted it under SCHIP.[66]

Klein explains that in addition to ensuring quick access to care, presumptive eligibility allows states to involve community-based organizations in enrollment as well as outreach. In turn, families can learn about children's health insurance and receive application assistance from familiar and trusted sources. A national survey of low-income families with uninsured children showed that parents were more likely to enroll their children in Medicaid if they could enroll immediately upon receiving services and provide forms later.[67] A downside of presumptive eligibility is that it will increase the number of ineligible children who are enrolled and receive services and will also increase disenrollment rates when these children are disenrolled. There is also some risk that presumptive eligibility, because it provides coverage at the point of service, could encourage families to use the programs for episodic and sporadic acute care rather than for preventive care. It may be appropriate, therefore, for states to monitor the effect of presumptive eligibility on care-seeking behavior and to provide education or other supports to encourage sound program utilization by children enrolled through the process.

Coordinate with Other Public Programs

Another potentially effective approach is to coordinate enrollment for health insurance with enrollment in other public benefit programs. Many uninsured children are enrolled in other public programs that have eligibility requirements similar to Medicaid and SCHIP.[68] For example, 63% of low-income, uninsured children are in families that receive food stamps or participate in nutrition programs such as the National School Lunch Program or the Special Supplemental Food Program for Women, Infants, and Children (WIC). Through a strategy known as express lane eligibility, Medicaid and SCHIP are linked with other public programs that target children in low-income families. An uninsured child's enrollment in those programs can then serve as a basis for qualifying that child for public health insurance.[69] Using this approach, states and other organizations can take affirmative steps to ensure that children who are enrolled in other public benefit programs are enrolled in health insurance as well.

Approaches of varying intensity are possible. For example, application for or enrollment in other public

benefit programs could be used as the basis for outreach to families for Medicaid or SCHIP. Joint applications could be developed for these programs, and enrollment in the health insurance programs could be facilitated by the staff and systems that handle enrollment into the other programs. A potential limitation of this approach is that several of the public benefit programs (specifically the nutrition programs) have less stringent enrollment criteria than do Medicaid or SCHIP—they typically do not require verification of income or citizenship. Accordingly, linking these programs to Medicaid and SCHIP may subject participants in the other programs to a more rigorous level of scrutiny and may theoretically lead to a reduction in participation in the other programs. It may be prudent, therefore, to approach program coordination efforts cautiously and to monitor the impact of these efforts not only on enrollment in public health insurance programs, but on enrollment in the other public benefit programs as well.

Linking outreach for Medicaid and SCHIP to application for employment insurance or to job termination procedures may be another effective but underutilized way of boosting program participation and cushioning the impact of job loss on families with children. Because the majority of children obtain health insurance through their parents' employment, a parent's job loss can trigger an episode of uninsurance. Although families have the option under COBRA of continuing coverage for up to 18 months after a job termination, this unsubsidized coverage is unaffordable for many low- to moderate-income families. Job loss may also trigger a reduction in family income, which may make a child eligible for Medicaid or SCHIP. Accordingly, it appears likely that the time of application for unemployment insurance, or the formal exit interview at which employees are informed of their COBRA options, presents an opportunity to enroll children in public health insurance programs. This opportunity was explored in Congress in late 2001 and early 2002 in response to the rapid rise in unemployment that followed the terrorist acts on September 11, 2001, but interest in such linkages waned because of difficulties in working out the details of how to target coverage to those affected indirectly by the attack.

RECOMMENDATION: Coordination with Other Programs

States should coordinate enrollment in public health insurance programs with enrollment in other public benefit programs that target low-income children (such as school lunch and food stamp programs) to increase children's coverage.

Sustain Outreach Efforts

The launch of SCHIP in 1998 spurred intensive efforts to make the public aware of the new program and to actively encourage enrollment. SCHIP's objective of reducing the number of uninsured children in the United States dramatically influenced Medicaid's outreach and enrollment procedures. For the first time, a public health program emphasized the importance of program promotion and active efforts to enroll eligible children. As described by Perry in this journal issue, states developed a range of marketing strategies to promote their public programs, including choosing appealing names and engaging the media, churches, and schools in enrollment campaigns.[70] Most states (73%) promoted their SCHIP and Medicaid programs jointly, which likely increased enrollment in both.[71] Some states report that they enrolled several eligible but previously uninsured children in Medicaid for every child enrolled in SCHIP.

Yet budget constraints and an economic downturn have severely constrained states' ability to continue with their public education and media campaigns. State budget shortfalls not only put pressure on outreach budgets directly, but also create strong incentives to reduce outreach efforts in order to slow or reverse the growth in program enrollments and program expenditures. Nonetheless, sustaining intensive outreach and public education efforts is necessary to reduce the high numbers of uninsured children who are eligible for public coverage but not enrolled—especially since lack of knowledge about program availability and not valuing coverage remain important impediments to participation.

At this point in the evolution of the SCHIP and Medicaid programs, targeting outreach and public education

campaigns to specific groups with elevated rates of uninsurance, such as children in immigrant families, other minorities, and adolescents, may make good use of limited funds. Outreach to immigrant families should be in their own languages, should employ culturally appropriate messages to educate parents about the value of coverage and how to access the system, and should seek to allay inappropriate fears that program participation will jeopardize a family's stay in the United States. Similarly, adolescents need outreach programs that speak to their needs and concerns. Lastly, outreach to families made eligible for SCHIP or Medicaid as a result of the economic downturn may be particularly valuable if these families have not interacted with public assistance programs in the past. For all these groups, outreach from community-based organizations and institutions—and from other public benefit programs such as unemployment insurance—can be cost-effective.

Working with Community-Based Organizations

Increasingly in recent years, states have partnered with community-based organizations and institutions as part of their outreach efforts, opening new opportunities for reaching vulnerable populations such as adolescents and immigrants. SCHIP administrators have developed partnerships with community-based organizations to assist with enrollment in public health coverage and to complement broad outreach and marketing campaigns. Unlike Medicaid regulations, federal SCHIP regulations allowed states to use a variety of organizations to determine a child's eligibility for coverage.[72] SCHIP used this flexibility to leverage the trusting relationships that families develop with familiar organizations they deal with frequently, such as schools and community health clinics. One study showed that California families who received assistance from community organizations during the application process were approved for coverage at a higher rate than those who did not receive assistance.[73] In particular, Cohen Ross and Hill note in this journal issue that community organizations may provide invaluable assistance for families that do not speak English, have concerns about how program participation might impact their immigration status, or simply need a convenient place to apply during off hours. Culturally competent, community-based organizations can be an effective way to reach uninsured immigrant children. In addition, some communities have existing traditions of health-related outreach that programs can incorporate into their efforts to reach eligible children. For example, in the article by Lessard and Ku in this journal issue, the *promotoras* in many Latino communities are highlighted as a useful resource for helping families navigate public programs.

In addition, community organizations have provided important feedback to program administrators that has resulted in improved applications. For instance, in response to input from schools and community groups that staffed an enrollment event in the public schools, Chicago shortened its application and clarified that parents did not have to provide their own Social Security numbers when applying for coverage for their children.[74]

RECOMMENDATION: Outreach and Education

States and the federal government should maintain outreach and public education as a priority and should work with community-based organizations to target children who are disproportionately uninsured, such as adolescents, minority children, and children in immigrant and newly unemployed families.

Focusing on Vulnerable Populations

Rates of uninsurance and access to appropriate care among children vary along dimensions such as family income; parental work status; age, race, and ethnicity; citizenship status; geographic location; and need for care. Some groups of children, such as adolescents and children in immigrant families, particularly Latinos, have a higher risk for being uninsured. These two groups of children, as well as children with special health care needs, would all benefit from health insurance programs that are responsive to their high-priority needs and concerns. Three articles in this journal issue discuss the challenges of reaching difficult-to serve populations and describe strategies for serving these vulnerable children more effectively.

Tailoring Programs to Accommodate Children with Special Health Care Needs

Preliminary data from the first nationwide survey of children with special health care needs (SHCNs) indicates that children with special needs represent 15% to 18% of the total population of American children. Although the

term "special health care needs" has been defined in a number of ways, these children tend to have chronic conditions and a high need for services, especially specialty and ancillary care. Accordingly, care for these children accounts for almost 50% of all health care expenditures for children.[75] Children with SHCNs are also especially vulnerable to adverse health outcomes and are therefore an important group to consider when designing public health insurance programs.

In an article in this journal issue, Szilagyi reviews the publicly funded programs that serve children with SHCNs and describes the challenges and opportunities involved in their care. In addition to Medicaid and SCHIP, children with SHCNs are also served by Title V of the Social Security Act, which provides money to states for community-based programs; Supplemental Security Income (SSI), also a Social Security program, which provides cash assistance to families to help with expenses related to disabilities; and Katie Beckett waivers, which allow states to use Medicaid funds to cover health care for children with SHCNs who otherwise would be ineligible and would have to forgo needed care. As Szilagyi notes, Medicaid is particularly well suited for children with SHCNs because it offers a very comprehensive benefit package and is an entitlement with little or no cost sharing. In fact, families of children with SHCNs are generally more satisfied with the care provided through Medicaid than they are with private insurance coverage.[76] A consistent finding, however, is that Medicaid's low reimbursement rates for providers make many providers reluctant to care for children with SHCNs, which can limit children's access to appropriate care.

Although most separate SCHIP programs offer children with SHCNs a richer, more appropriate benefit package than the typical commercial plan, many basic SCHIP plans fall short of Medicaid in providing for children with SHCNs. Some states try to supplement basic SCHIP benefits with wraparound coverage (additional coverage, such as for dental or rehabilitation services) or carve-out programs (special service delivery programs, such as for mental health services), but these arrangements may complicate access to and coordination of services, and there is yet little systematic evidence as to how well these arrangements are working.

In addition, some states require that children be uninsured for anywhere from one to six months before enrolling in SCHIP.[77] The purpose of this provision is to discourage families with employer-sponsored insurance from switching to SCHIP. Yet, as Szilagyi notes, such waiting periods present a particular risk for children with chronic or urgent medical conditions who need health coverage without delay. Some states have attempted to remedy this problem by exempting children with special needs from waiting periods.[78] Other states have exempted children from waiting periods if their families have spent more than a certain proportion of their income (for example, 5% in Connecticut) on health care.[79]

Szilagyi also identifies a number of ways in which health insurance programs for children, private as well as public, could be improved, including enhanced outreach, improved wraparound (supplemental) services, strengthened provider networks, financial incentives appropriate for the additional costs of caring for children with SHCNs, improved care management and cross-program collaboration, and enhanced quality-monitoring and quality-improvement programs.

RECOMMENDATION: Children with Special Health Care Needs

States should monitor how well their Medicaid and SCHIP programs are serving children with special health care needs in the areas of enrollment, scope of benefits, access to providers, and coordination of care, and take appropriate action to improve performance.

Adolescents

Adolescence is a unique developmental stage of accelerated growth, when a number of physiological, cognitive, social, and emotional changes occur simultaneously. As a result, according to Brindis and colleagues in this journal issue, prevention, early intervention, and health education are especially important for adolescent children. Yet, adolescents are significantly less likely than their younger peers to have health coverage, and participation rates in public programs are lower for eligible teens than for eligible children under age six.[80] Low insurance rates among adolescents are troubling because the transition from childhood to adulthood represents a critical oppor-

tunity to prevent the onset of health-damaging, risky behaviors such as smoking, substance abuse, or unsafe sex, which can lead to lifelong health problems and unwanted pregnancies.

Although historically the Medicaid eligibility standards for adolescents were more restrictive than for younger children, program expansions in the late 1980s through the early 1990s and the creation of SCHIP in 1997 greatly increased adolescents' eligibility for public health insurance. These expansions of coverage equalized eligibility thresholds for children of different ages, but studies show that low-income parents of adolescents are still less likely to think their children are eligible for public coverage than parents with younger children.[81] As a result, the uninsurance rate among adolescents (children ages 10 to 18) is about 14%, with even higher rates among low-income and minority adolescents.[82]

To increase participation by adolescents in public health insurance programs, more attention needs to be paid to developing effective outreach and enrollment strategies and to providing a health care delivery system that is responsive to adolescents' needs and concerns. Little is known about which outreach strategies are effective in reaching adolescents generally or what works with specific subpopulations of youth who are at high risk for health problems. Brindis and colleagues recommend that states work with service organizations, schools, and health care providers to develop, implement, and evaluate outreach strategies targeted to adolescents. Once enrolled, adolescents will also need education on how to access services, because many adolescents may want to access services independently of their parents.

Adolescents need a broader set of health care services than do younger children (for example, family-planning, reproductive health, mental health, and substance-abuse services) and may access services in different venues (school-based and family-planning clinics, for example) than younger children. In addition, studies show that assurances of confidentiality increase adolescents' effective use of care and that without confidentiality protection some adolescents will forgo care. However, not all states have modified their Medicaid and SCHIP programs to address adolescents' needs. For example, some programs do not cover appropriate preventive services for adolescents in accordance with the most current guidelines. Restrictions on mental health and substance-abuse-treatment benefits, which may apply as well to younger children and adults, may have greater significance for adolescents than they do for other age groups. Lastly, although all states offer some confidentiality protections to adolescents under age 18, Brindis and colleagues report that more could be done to improve the policies and practices of health plans and health care providers to assure confidentiality protections for adolescents.

Brindis and colleagues identify two groups of adolescents needing special attention: those leaving foster care and those leaving the juvenile justice system. Many adolescents who leave the foster care system at age 16 or older have serious unmet physical and mental health needs, but lack familial and financial supports. These highly vulnerable adolescents are covered by Medicaid while in foster care, but become uninsured after leaving foster care because few states have taken advantage of a federal option to expand Medicaid coverage to age 21 for members of this population. Similarly, many youth in the juvenile justice system experience significant behavioral problems and acute and chronic medical conditions. While in custody, these youth receive care through the juvenile justice system, but many of their problems persist when they leave custody. Because many of these youth are eligible for Medicaid or SCHIP upon their release from custody, Brindis and colleagues recommend screening these young people for eligibility for these programs upon their release.

RECOMMENDATION: Adolescents

States should experiment with special outreach efforts to increase adolescent participation in Medicaid and SCHIP and should closely monitor how well these programs are meeting adolescents' needs.

Immigrants

The United States is a nation of immigrants, yet many children in immigrant families are not covered by health insurance. One in five children under age 18 is either an immigrant or a member of an immigrant family (see the article by Lessard and Ku in this journal issue for a

detailed description of different categories of immigrant families).[83] The majority (75%) of these children are native-born citizens, while 25% are noncitizens. Since 1990, the number of children in immigrant families has increased seven times faster than the number of children in nonimmigrant families. As Lessard and Ku put it, one of the most important risk factors for lack of health insurance among children in the United States is family immigration status. One in four uninsured children lives in an immigrant family.[84]

A subset of immigrant children is barred from participating in Medicaid and SCHIP by eligibility restrictions, but many low-income children in immigrant families are in fact eligible for coverage, but not enrolled. Eligible children remain without coverage because their families encounter too many obstacles (for example, language barriers and documentation requirements) while trying to enroll them, are confused about program availability and eligibility, or fear the possible repercussions of accessing public benefits. In their article, Lessard and Ku outline a number of suggestions for addressing these barriers.

Several studies have documented the negative impact of welfare reform on immigrant children's use of public health insurance programs and other benefits.[85] Some of the confusion about eligibility stems from the new categories of eligibility for all public benefits, including health insurance, created when Congress reformed federal welfare policies in 1996. These new categories distinguish between immigrants who entered the United States before and after August 22, 1996, the date the law was passed.[86] Overall, as Lessard and Ku note, the proportion of eligible immigrant children covered by Medicaid and SCHIP dropped by nearly 8% after the 1996 welfare law was enacted.[87]

In addition, the anti-immigrant policy climate of the 1990s appears to have eroded immigrants' confidence in their ability to access public benefits without repercussions even if they are eligible.[88] For instance, in a recent three-city (San Francisco, Miami, and New York) survey of Latina mothers who had just given birth, those who lived in California were six times more likely to report facing obstacles and a sense of fear when they attempted to access publicly provided health care services than similar women in New York and Florida.[89] Common concerns were that applying for public health insurance would jeopardize their immigration status or make it more difficult to become citizens and that they would someday have to reimburse the government for health care costs. Such concerns acted as barriers to participation for many women who were eligible for coverage. A series of California policies, such as Proposition 187, a 1994 ballot measure that would have restricted the access of undocumented immigrants to most public services, appear to have contributed to an environment of anxiety among immigrants.

Overall, the restrictions on providing coverage to legal immigrant children in the 1996 federal welfare law appear to have adversely affected the participation of eligible children in immigrant families as well. The situation is made more confusing by a provision of the legislation that allows children to enroll in federally funded Medicaid and SCHIP programs after five years of residence in the United States. Coupled with the fact that children born in the United States are citizens and so are eligible for coverage, this provision means that immigrant families can have children in multiple eligibility classifications that will change over time. Fortunately, several states have offered Medicaid and SCHIP coverage to legal immigrant children with state funds; however, these programs may be in jeopardy when state budgets are constrained.

Restore Eligibility for Legal Immigrant Children

Restoring federal eligibility for public health coverage for those who lost coverage as a result of welfare reform in 1996 would have several major benefits. It would provide coverage to a number of low-income immigrant children currently barred from participating in public programs they would have been eligible for prior to August 22, 1996; simplify the application processes for these programs for all children; reduce the anxiety and concern that immigrant families feel about accessing public health coverage for their children; and perhaps, therefore, increase participation in these programs by currently eligible children. Federal support would be especially important now, when states that are providing this coverage without federal funds are facing revenue shortfalls. Moreover, restoring these benefits would make federal policy toward legal immigrant children more consistent. Last year, the food stamp eligibility that had been revoked for these children in 1996 was restored, and they remain eligible for federal nutrition programs such as school lunch and WIC.

RECOMMENDATION: Legal Immigrant Children

The federal government should restore its funding for public health insurance programs for legal immigrant children who lost coverage following the enactment of welfare reform in 1996.

Cover Low-Income Children Regardless of Immigration Status

Restoring federal eligibility for all legal immigrant children would not help the undocumented immigrant children who comprise 6% of uninsured children. All states are required to cover eligible immigrants' emergency medical care under Medicaid, and some states allow children to enroll in advance for the emergency care benefit. Even though enrolling children in strictly limited programs is not ideal, enhancing access to emergency care could lead to earlier and less costly interventions.[90]

Although extending health coverage to undocumented immigrant children may seem to be a daunting political challenge, ample precedent to do so exists. Lessard and Ku describe initiatives in several states and localities to insure immigrant children, regardless of immigration status.[91] They also note that undocumented children are currently eligible for nutrition programs such as school lunch and breakfast. There is also strong reason to believe that eliminating immigration status as a factor in program eligibility could substantially increase participation by children in immigrant families who are eligible under current law, but who do not enroll because of confusion or concerns that the immigration status of other family members could be threatened by their participation.

Expanding federal coverage to include undocumented children will also provide fiscal relief to states and safety net providers. Three states and the District of Columbia use their own funds to provide at least some coverage for undocumented children. In addition, to the extent that state and locally funded safety net providers end up serving the health care needs of low-income immigrant children with little remuneration, federal participation in the funding of health insurance for these children can help reduce state and local outlays and shore up safety net providers.

Provide Linguistic and Culturally Competent Assistance

For children in immigrant families, restoring or expanding eligibility for Medicaid and SCHIP will not alone guarantee enrollment or access to health care services. Immigrant parents and their children will need linguistically and culturally competent assistance in applying for benefits and using the health care system. As previously discussed, trusted community groups can play that role as well as help allay concerns that getting medical assistance might endanger a family's immigration status. In addition, because linguistic and cultural competence are integral to quality health care, efforts (resources, administrative procedures, and monitoring) to assure the greater availability of such care should be part of any attempts to service this population.

Lastly, although there are many ongoing evaluations of the impact of coverage expansions on children, little is known about how coverage expansions impact children in immigrant families. This issue requires more research to help us understand how to effectively reach, enroll, and serve these children, as well as to measure the benefits they may derive from coverage. In addition, because of concerns about the possible adverse effects of expanding coverage for immigrant children on state budgets and immigration patterns, these two issues should be studied as well.

RECOMMENDATION: Undocumented Children

States and the federal government should expand Medicaid and SCHIP coverage to all low-income children regardless of immigration status and should provide linguistically and culturally appropriate services to ensure that all children can benefit from the expanded coverage.

Next Steps: Expanding Coverage to More Children and to Parents

Though SCHIP and Medicaid have made substantial progress in filling the gaps in health coverage for children in families that cannot afford private insurance, many children still fall through the cracks between public and private health insurance programs. Two ways to improve coverage for children are raising the

income eligibility level for SCHIP and expanding SCHIP coverage to parents.

Raising SCHIP Income Eligibility

In addition to children in immigrant families, many other low-income children lack coverage, because not all states have increased coverage under SCHIP to 200% of the FPL. Even at that level, some uninsured children in families with somewhat higher incomes do not qualify for public coverage, but nonetheless have difficulty affording private coverage. As was pointed out earlier, further expanding SCHIP eligibility to uninsured children in families with income below 300% of the FPL could provide coverage for 5% of all currently uninsured children.

Ten states have taken advantage of available SCHIP funds and the generous SCHIP federal matching rate to expand coverage to children in families with incomes above 200% of the FPL. (New Jersey has the highest eligibility level at 350%.) Many of these programs impose modest cost sharing on families in the form of premiums and co-payments for services. Cost-sharing requirements typically increase as family income rises. New York charges the full cost of its SCHIP program for families with incomes above 208% of the FPL, but most states continue to substantially subsidize their programs for families with incomes above 200% of the FPL.

One reason for expanding eligibility for public programs above 200% of the FPL is variation in the cost of living. For example, several counties in the San Francisco Bay Area have recently launched locally financed programs to cover children in families with incomes up to 300% or 400% of the FPL (California covers children to 250% of the FPL in its SCHIP program). These programs attempt to address the very high cost of living in the Bay Area. Another reason to consider expanding eligibility for public health insurance to uninsured children in families with incomes between 200% and 300% of the FPL is that about one-half of these children reside in families that do not have access to employer-sponsored coverage.

Expansion of public coverage to children in families with incomes up to 300% of the FPL will require some special considerations, however. First, because approximately 50% of uninsured children in families with incomes between 200% and 300% of the FPL have access to employer-sponsored coverage, coverage expansions to this group might be accomplished at lower cost through employer buy-in programs. Coordination with employer-sponsored insurance may be easier to administer in this income range because there may be less need to compensate for the higher cost sharing and more limited scope of benefits frequently associated with private insurance for this group of children than for children in families with lower incomes.

Second, because within this income band there are almost 10 times as many children with employer-sponsored coverage as there are uninsured children, public programs for this population should be designed to minimize crowd-out. Cost-sharing arrangements (premiums and co-payments) of a magnitude more like generous employer-sponsored programs than public programs may be appropriate for this income group. However, very little is known about why children in this income band are uninsured or how these program features might affect their participation in public programs, use of services, or propensity to switch from private to public programs. So it may be valuable to include a research and evaluation component in further public program expansions to children in higher-income families to get the answers to these key program design questions.

RECOMMENDATION: Income Eligibility Levels

All states should increase eligibility under SCHIP to include all children in families with incomes up to 200% of the federal poverty level, as intended in the SCHIP statute, and, as funds become available, experiment with expanding coverage to children in families with incomes up to 300% of the federal poverty level.

Cover Entire Families

Some states and researchers have begun to test the relationship between reaching and enrolling uninsured children and expanding health insurance to parents.[92] Nearly 75% of uninsured children who are eligible for Medicaid or SCHIP have at least one parent who is uninsured.[93] Of these 9 million uninsured parents, nearly three out of four work, earning below 200% of the FPL at jobs that often offer limited or no health insurance coverage.

In studies that compared children's Medicaid enrollment in states that expanded Medicaid to include parents versus states that did not cover parents, children were found to have higher rates of Medicaid participation in states that had instituted broader expansions.[94] One study found that an expansion of the Medicaid program to cover parents in Massachusetts led to a 14 percentage point increase in Medicaid coverage among children, most of whom had already been eligible for Medicaid.[95] When Rhode Island expanded its SCHIP program to cover parents, the number of children who enrolled increased by 47% over three years, compared to an increase of 10% over three years before the expansion to parents.[96]

Evidence also suggests that parental insurance coverage affects the quantity and quality of the care children receive—even if the children themselves have no coverage. Children are two to three times more likely to see a doctor if their parents have seen a doctor, and parents with insurance are more likely to seek care.[97] In addition, a recent Institute of Medicine report observed, "[I]f just one member of a family does not have health insurance, it adversely affects the health, emotional well-being and financial stability of the entire household."[98] The report cites evidence that parents' poor physical or emotional health can undermine their children's emotional health and development and can lead to poorer school performance, difficulty with socialization, and higher rates of emotional disorders.

Private employer-sponsored health insurance is the primary source of coverage for adults in the United States; however, the availability of employer-sponsored coverage is highly correlated with earnings, with the result that many low-income parents do not have access to employer-sponsored coverage. Recent public policy changes, however, have increased states' options for covering low-income parents under Medicaid or SCHIP. The provisions of PRWORA (the federal welfare reform law) decoupled Medicaid from cash welfare benefits and made it easier for states to cover more low-income parents under Medicaid. Five states had adopted this approach by July 2000. In addition, 10 states have used Medicaid 1115 waivers, and 4 states have used SCHIP 1115 waivers to cover parents. (These demonstration waivers allow the Secretary of Health and Human Services to waive provisions of the Medicaid and SCHIP laws for research and demonstration purposes that further the interests of the programs.) States that most recently implemented SCHIP parental expansions report that they quickly met or exceeded their enrollment targets for parents.[99]

The recent economic downturn and ensuing state budget shortfalls have dampened interest in large-scale expansions of public coverage for parents. For example, California has twice delayed a major expansion of its SCHIP program to cover parents in families with incomes between 100% and 200% of the FPL, and the governor has proposed a rollback of the Medicaid family income-eligibility level for parents from 100% to 63% of the FPL. Most parental coverage is optional under Medicaid and SCHIP, and parents are more expensive to cover on a per-capita basis than are children. States are showing more interest in using Medicaid and SCHIP funds to provide family coverage by buying into employer-sponsored coverage (as described above), however, and the federal government has signaled its willingness to help facilitate these buy-in plans by reducing some of the regulatory complexities that made these plans difficult to administer in the past.

Conclusion

Medicaid and SCHIP have provided a blueprint for successfully insuring low-income children. Although these programs have yet to completely fulfill their promise, the encouraging news is that the programs need only be improved and expanded to continue to make major inroads in reducing the numbers of uninsured children in the United States.

The articles in this journal help provide a picture of what these programs might look like if they fulfilled their promise. All eligible children would be enrolled and would continue to receive health coverage for as long as they needed it. The programs would be financed in a manner that reflects the reality that demand for public coverage increases during economic downturns. Federal funding would be stable, secure, and adequate to meet the needs of programs and would provide incentives for states to cover as many eligible children as possible. In addition, federal matching rates for Medicaid and SCHIP would be equalized to make states indifferent to covering children under Medicaid or SCHIP. Federal funding would also acknowledge the extent of Medicaid's responsibility for providing health coverage to the nation's

neediest children. Finally, the financing problems that threaten SCHIP would be resolved. States, for their part, would behave responsively to make sure that programs were adequately funded over the long run, regardless of the state of the economy, and that benefit packages and the level of provider reimbursement were adequate to assure children access to appropriate care.

In light of the interdependent and complementary relationship of Medicaid and SCHIP, systems for the two programs would be streamlined and aligned. Relevant application information would be shared efficiently using up-to-date technologies, and administration for both programs would be seamlessly coordinated. The programs would also coordinate with private coverage and other public programs to make sure children maintain coverage as their family circumstances change.

As this journal issue goes to press, the U.S. health care sytem continues to be buffeted by the same forces—rising costs, high and rising rates of uninsurance for some groups, gaps in coverage for others (including the elderly), concerns about quality, and disgruntled providers—that have plagued the system for many years. It is possible that the current "crisis" will spawn a revolutionary set of reforms and restructuring that will successfully address these problems. If not, it would appear that the next best achievable outcome for children would come from continuing to build on the insurance systems in place to expand and assure children's access to appropriate medical care. As U.S. Representative Henry Waxman, a driving force behind expansions of Medicaid coverage for children, once observed, "Incrementalism may not get much press, but it does work."[100]

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Historical Overview of Children's Health Care Coverage

Cindy Mann, Diane Rowland, and Rachel Garfield

SUMMARY

America's public health insurance programs reflect a deeply rooted commitment to caring for low-income families and children. This article chronicles the evolution of Medicaid and the State Children's Health Insurance Program (SCHIP), two public programs designed to provide free or low-cost health coverage to low-income children who do not have access to private health insurance. Such a historical overview is key to understanding where the programs come from and the challenges that policymakers must grapple with in order to effectively provide health coverage to children.

Depression-era maternal and child health programs created the foundation for Medicaid. Expansions of the program during the 1980s and 1990s made Medicaid the largest single insurance provider for children in the United States. In 1997, SCHIP boosted these efforts by filling the gap between Medicaid and employment-based coverage. In addition to expanding coverage, SCHIP also motivated efforts to address obstacles to coverage such as application and enrollment procedures. Together, SCHIP and Medicaid have made significant progress in providing health coverage to children in low-income families. They are the primary sources of coverage for children in low-income families.

In a discussion of major challenges to providing public health coverage to children, the authors highlight some important issues that threaten current progress, such as rising health care costs and falling state revenues, gaps in coverage, and remaining barriers to enrollment and retention.

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America's commitment to assuring health care for its poorest children has developed over several decades. Rooted in the maternal and child health programs of the Depression era, health coverage became an entitlement for low-income children with Medicaid's enactment in 1965 and subsequent expansions in Medicaid coverage for children in the 1980s and 1990s. The 1997 creation of the State Children's Health Insurance Program (SCHIP) boosted these efforts by further expanding federal financing and state options for coverage of low-income children.

The development of publicly funded health coverage for children reflects an effort to fill in a significant gap in the privately based health system: Although most Americans have access to health insurance through their jobs or through the jobs of family members, not all children have access to employer-based coverage. Nationally, more than two-thirds of all children have some type of private health insurance coverage, with most (63%) obtaining their coverage from an employer-sponsored group health plan offered to their parents in the workplace. For low-income children who do not have private coverage, public coverage plays a critical role. One in every five children (20%) and 41% of low-income children are covered by Medicaid or SCHIP.[1] Yet, 12% of children remain without any coverage at all.[2]

Whether publicly or privately sponsored, health insurance improves children's access to care, enables them to benefit from early preventive and primary care, and contributes to improved health status. On any measure of access to care, uninsured children persistently lag behind those with public or private coverage.[3] As these disparities have become more apparent, there have been renewed efforts to assure coverage for all children.

This article provides an overview of the evolution of publicly sponsored coverage over the past four decades through Medicaid and, most recently, SCHIP; the current state of health coverage for children; and remaining challenges. It concludes with a discussion of lessons learned from experiences with Medicaid and SCHIP that can inform future efforts to improve health coverage for America's children.

The Evolution of Public Health Coverage for Children

While the most recent developments in coverage for children were prompted by the adoption of SCHIP in 1997, public health insurance for children has a long history (see Box 1). Much of this history is inextricably linked to the development of cash assistance programs to support low-income families with children. For the past two decades, however, broad, consistent political support for health coverage for children has extended publicly funded coverage for children well beyond traditional welfare populations. Today, most low-income children are eligible for coverage through Medicaid or SCHIP.

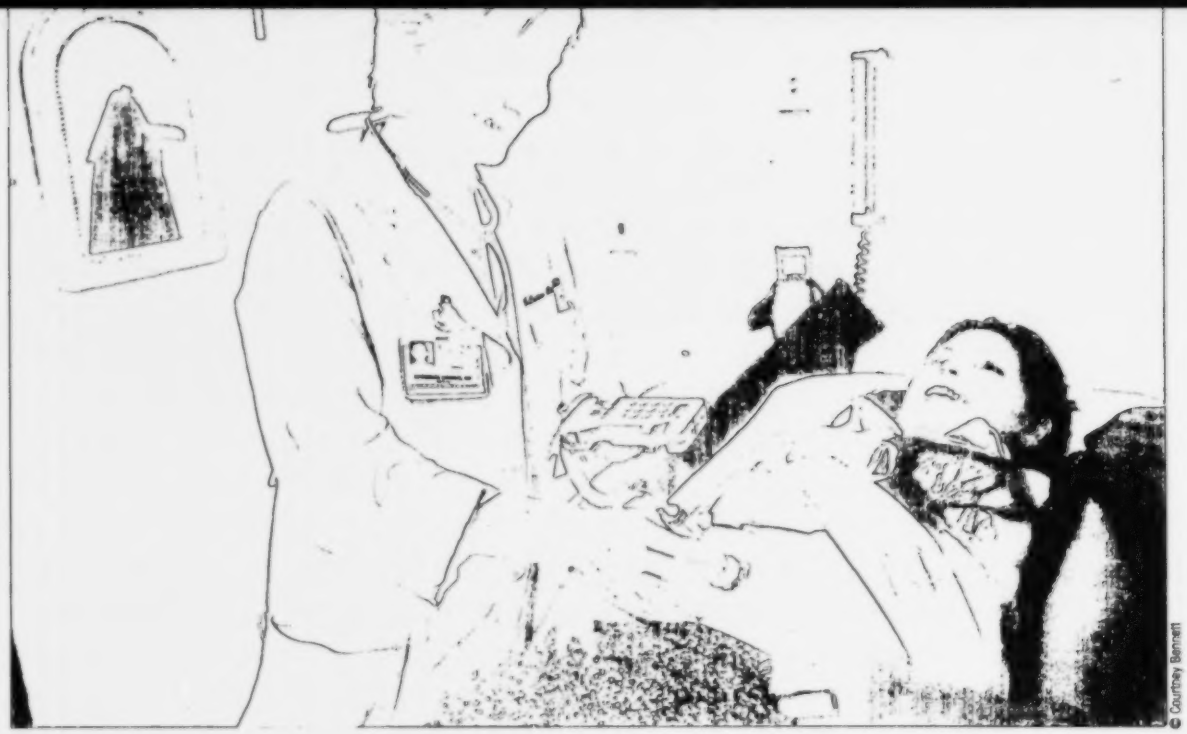
Depression-Era Maternal and Child Health Programs

Assisting families with dependent children was among the priorities leading to the enactment of the Social Security Act in 1935. In response to the Great Depression, the act not only established the nation's retirement benefit and unemployment insurance systems, but it also created the nation's public assistance system. As part of the public assistance provisions, states were permitted to provide additional funds to families receiving welfare to help cover the cost of medical care. Not until the Social Security Amendments of 1950, however, could states make direct payments to providers for medical care delivered to welfare recipients.[4]

Title V of the Social Security Act of 1935 also established "Grants to States for Maternal and Child Welfare." Based on the work of the 1912 Children's Bureau, these grants provided states with funds for direct services to children.[5] Funds were provided based on a formula, with fixed allocations to each state. States generally used Title V funds to provide traditional public health programs—such as immunization and infant mortality prevention—and to provide services to children with special health care needs.[6]

Medicaid and Medicaid Expansions

The enactment of Medicaid as part of the Great Society program was a major advance in providing medical coverage to low-income Americans. Medicaid, or Title XIX of the Social Security Act, was enacted in 1965 as companion legislation to the Medicare program for the elderly. Building on the model of the earlier Kerr-Mills program for the medically indigent aged population, Medicaid was structured as a joint federal–state pro-



gram.[7] The federal government provides matching funds—or payments to states for a share of the costs they incur for services provided to Medicaid beneficiaries—and sets broad guidelines for eligibility and scope of coverage. The states administer the programs and make specific decisions about eligibility and benefits. State participation in Medicaid is voluntary, but states that choose to participate and receive federal funds must meet federal guidelines. Federal law also allows flexibility by giving states the option to expand their programs' eligibility or to offer benefits beyond the minimums, and by granting states broad discretion to set provider payment rates and establish health care delivery systems. The federal government currently pays about 57% of program costs.[8]

Medicaid was designed to give federal financial support to states to help provide medical assistance to families, the aged, and disabled individuals who were receiving welfare. For families with children, eligibility for Medicaid was primarily based on receipt of cash assistance through the Aid to Families with Dependent Children (AFDC) welfare program. Enacted during the Depression as part of the original Social Security Act of 1935, AFDC provided states with federal matching funds for cash assistance to needy children and their parents.[9] In general, a family was eligible for AFDC if it had a "dependent" child and an income below its state's "need standard" (also called an income-eligibility standard), the level of income and assets the state determined a family needed to live. Most families who qualified were single-parent households with little or no income.

Amendments to the Social Security Act adopted in 1967, just two years after the enactment of Medicaid, made significant changes to the program. One change gave states the option to cover low-income children who were not receiving cash assistance. This option laid the groundwork for the later expansion of Medicaid's role to provide health coverage based on income, not welfare status.

The 1967 amendments also included provisions to broaden beneficiaries' access to care. Most significant for children was the creation of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program within Medicaid.[10] EPSDT extended Medicaid's role from paying for health services to assuring that children receive comprehensive preventive care and follow-up for health problems. With the addition of EPSDT, Medicaid not only entitled children to the basic Medicaid services (for example, hospital, physician, laboratory, and nursing home services), but it also required states to provide health screenings at regular intervals.[11] Later amendments further strengthened Medicaid's role for children. Under Medicaid's original rules, services were available to children with very limited contributions from families toward the cost of care. Amendments adopted in 1982 eliminated cost sharing for children, assuring that health services for children would be

Box 1

Medicaid and SCHIP Coverage of Children: Legislative History, 1965–2001

This summary outlines the major changes in publicly funded coverage for children enacted by Congress since the initiation of the Medicaid program in 1965. This legislative history is not comprehensive; it includes only the most significant of the changes in Medicaid eligibility, benefits, and financing policy for nondisabled children, and the enactment of the State Children's Health Insurance Program. It does not include references to major changes that affected other groups of Medicaid beneficiaries or proposals that were debated by Congress, but not enacted, such as the Medicaid block grant proposals of 1981 and 1995.

Social Security Amendments of 1965
(Public Law 89-97)
- Enacted Medicaid as an individual entitlement with open-ended federal matching payments to states
- Required states that participated in Medicaid to cover children receiving Aid to Families with Dependent Children (AFDC) cash assistance
- Gave states the option to cover other children with incomes below AFDC income standards ("Ribicoff" children)

Social Security Amendments of 1967
(Public Law 90-248)
- Enacted Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, requiring regular periodic health screens for children
- Required states to allow Medicaid beneficiaries to use any providers who accepted Medicaid payment

Omnibus Reconciliation Act of 1981 (OBRA 81)
(Public Law 97-35)
- Limited AFDC eligibility, including restrictions in eligibility for families with earnings, which automatically limited eligibility for Medicaid
- Enacted the Section 1915(b) "freedom of choice" waiver to allow mandatory managed care in Medicaid

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
(Public Law 97-248)
- Allowed states to impose nominal cost sharing on certain Medicaid beneficiaries and services, but exempted children and pregnant women, among other groups

Deficit Reduction Act of 1984 (DEFRA)
(Public Law 98-369)
- Required coverage for children born after September 30, 1983, up to age five, in families meeting state AFDC income and resource standards (approximately 40% of the federal poverty level)
- Required coverage for first-time pregnant women and pregnant women in two-parent unemployed families meeting state AFDC income and resource standards
- Required nine months of "transitional medical assistance" for families who became ineligible for welfare due to earnings or child support
- Made infants born to mothers covered by Medicaid automatically eligible for one year of coverage

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law 99-272)
- Required coverage for pregnant women in two-parent families meeting state AFDC income and resource standards (that is, dropped the AFDC unemployed-parent criteria)
- Required coverage of children up to age five in families meeting AFDC income and resource standards

Omnibus Reconciliation Act of 1986 (OBRA 86)
(Public Law 99-509)
- Allowed states to cover pregnant women and young children up to age five in families with incomes at or below 100% of the federal poverty level (resource standards could be dropped)
- Allowed states to use presumptive eligibility and continuous eligibility for pregnant women

Omnibus Reconciliation Act of 1987 (OBRA 87)
(Public Law 100-203)
- Allowed states to cover pregnant women and infants with family incomes at or below 185% of the federal poverty level
- Required coverage for children up to age eight with family incomes below AFDC standards and allowed states to cover these children up to 100% of the federal poverty level

Box 1

(Continued)

Medicare Catastrophic Coverage Act of 1988 (MCCA)
(Public Law 100-360)

- Required the phase-in of coverage for pregnant women and infants with family incomes below 100% of the federal poverty level (retained when MCCA was repealed)

Family Support Act of 1988
(Public Law 100-485)

- Extended transitional Medicaid coverage to 12 months to families leaving AFDC due to earnings
- Required coverage of two-parent families meeting the AFDC unemployed eligibility test with incomes below AFDC income and resource standards, even if the state did not cover such families under AFDC
- Allowed states to cover pregnant women and children (among other groups) beyond minimum standards

Omnibus Budget Reconciliation Act of 1989 (OBRA 89)
(Public Law 101-239)

- Required coverage of pregnant women and children under age six in families with incomes at or below 133% of the federal poverty level
- Expanded the EPSDT benefit for children under age 21 to include diagnostic and treatment services that could be covered under Medicaid, even if the state Medicaid program did not cover these services for adult beneficiaries
- Required coverage of services provided by federally qualified health centers

Omnibus Budget Reconciliation Act of 1990 (OBRA 90)
(Public Law 101-508)

- Required phase-in (by 2002) of coverage of children ages 6 through 18 in families with incomes at or below 100% of the federal poverty level

Omnibus Budget Reconciliation Act of 1993 (OBRA 93)
(Public Law 103-66)

- Established the Vaccines for Children program, providing federally purchased vaccines to states

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)
(Public Law 104-193)

- Repealed the AFDC program and replaced it with a block grant to states (Temporary Assistance for Needy Families) and severed the linkage between eligibility for cash assistance and for Medicaid
- In lieu of the AFDC link, established the Section 1931 "family coverage" category, requiring coverage of families with children meeting July 16, 1996, AFDC income and resource standards and family composition rules and allowing higher eligibility thresholds at state option
- Barred Medicaid coverage for five years for most legal immigrants who entered the United States on or after August 22, 1996; allowed coverage after the five-year ban at state option

Balanced Budget Act of 1997 (BBA 97)
(Public Law 105-33)

- Established the State Children's Health Insurance Program, providing capped federal matching payments to states for coverage of uninsured, low-income children with incomes above March 1997 Medicaid standards (enhanced matching rate relative to regular Medicaid rate)
- Allowed states to require most Medicaid beneficiaries to enroll in managed care organizations (MCOs) without states obtaining Section 1915(b) "freedom of choice" waivers
- Allowed presumptive and continuous eligibility for children in Medicaid

Sources: Congressional Research Service for the Subcommittee on Health and the Environment. *U.S. House of Representatives Medicaid source book: Background data and analysis (1993 update).* Washington, DC: CRSSHE; Committee on Ways and Means, U.S. House of Representatives. *1998 green book.* Washington, DC: U.S. Government Printing Office. May 19, 1998; Committee on Ways and Means, U.S. House of Representatives. *2000 green book: Background data and data on the programs within the jurisdiction of the Committee on Ways and Means.* Washington, DC: U.S. Government Printing Office. October 2000; The Library of Congress. Thomas: Legislative information on the Internet. Available online at http://thomas.loc.gov/.

available at no cost to families. In 1989, further amendments required states to provide treatment for problems detected during EPSDT screenings.

Enrollment grew rapidly in the early years as states chose to participate in the Medicaid program and began covering eligible groups.[12] From the mid-1970s to the mid-1980s, however, enrollment of children slowed, and enrollment among poor children actually declined, largely because of the decline in AFDC eligibility.[13] Between 1972 and 1990, AFDC eligibility was restricted, and the real-dollar value of the AFDC income-eligibility standard fell by more than 40%.[14] Because eligibility standards for parents' and children's Medicaid coverage were largely linked to receipt of AFDC (rather than to a family's income relative to the federal poverty level [FPL]), decreases in AFDC eligibility automatically translated into reduced Medicaid eligibility for children and their families.

The reductions in Medicaid coverage resulting from Medicaid's ties to AFDC, along with reports of rising infant mortality rates, prompted congressional efforts in the early 1980s to improve pregnant women's and children's access to Medicaid and to sever the direct link between receipt of welfare and Medicaid eligibility for these two groups. Through omnibus budget bills, major federal legislative changes affecting Medicaid coverage of pregnant women and children were enacted each year beginning in 1984 and continuing through 1990.[15] Most notably, these changes began to base children's eligibility on family income, not welfare status, and opened up the program to children in two-parent families. For pregnant women and children, the federal minimum eligibility requirements adopted during this period still apply:[16]

- Under 1989 legislation, states participating in Medicaid were required to cover pregnant women and children under age six with incomes below 133% of the FPL.
- Under 1990 legislation, states participating in Medicaid were required to cover older children (ages 6 to 18) with incomes up to the FPL. This coverage was phased in over time by extending coverage to older children each year.

These legislative changes also gave states the latitude to cover children at higher income levels and still receive federal funding to help cover the cost of their care. At the same time, standards for physician payment were implemented in order to assure adequate provider availability for the covered population.

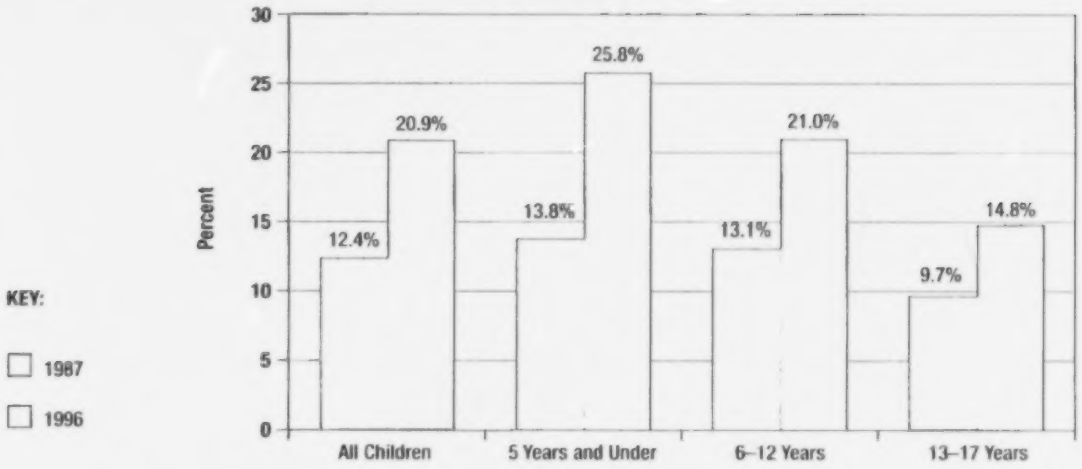
The establishment of federal minimum eligibility standards that were no longer tied to AFDC represented a major step forward for children. In 1992, only one state (Washington) covered children at all ages with incomes up to the FPL. Effective September 30, 2002, all children under age 19 with incomes below the FPL had to be covered under Medicaid in every state. Partly as a result of the new federal requirements and states taking up the option to cover children at higher income levels, the number of children enrolled in Medicaid grew steadily throughout the late 1980s and early 1990s. The most substantial increases occurred for younger children, who were the subject of the earliest federal mandates and options (see Figure 1).

As eligibility expansions increased the number of children covered by Medicaid, states grew concerned about rising program costs and the availability of Medicaid providers to serve new beneficiaries. With predictable costs through prepaid health care and the potential to tap into new provider networks, managed care became an appealing way to contain costs and enhance access to care for Medicaid beneficiaries. States soon began to transition from providing care on a fee-for-service basis to enrolling Medicaid beneficiaries—primarily children and their parents—in managed care plans. Increasing use of managed care in the private sector and easing of federal restrictions on the use of prepaid health plans in Medicaid[17] facilitated this shift in service delivery. Throughout the 1980s, Medicaid managed care grew steadily, and during the 1990s, enrollment increased more than sixfold.[18] In 1997, the use of managed care in Medicaid was made easier by the Balanced Budget Act, which allowed states to require most beneficiaries to enroll in managed care without states first obtaining special permission from the Secretary of Health and Human Services (as had previously been the case).

The passage of the 1996 federal welfare law (the Personal Responsibility and Work Opportunity Reconciliation Act, or PRWORA) completed the delinking of Medicaid eligibility and cash assistance for children that had begun in the late 1960s.[19] PRWORA repealed AFDC, replacing it with the Temporary Assistance for Needy Families

Figure 1

Percentage of Children Enrolled in Medicaid, by Age

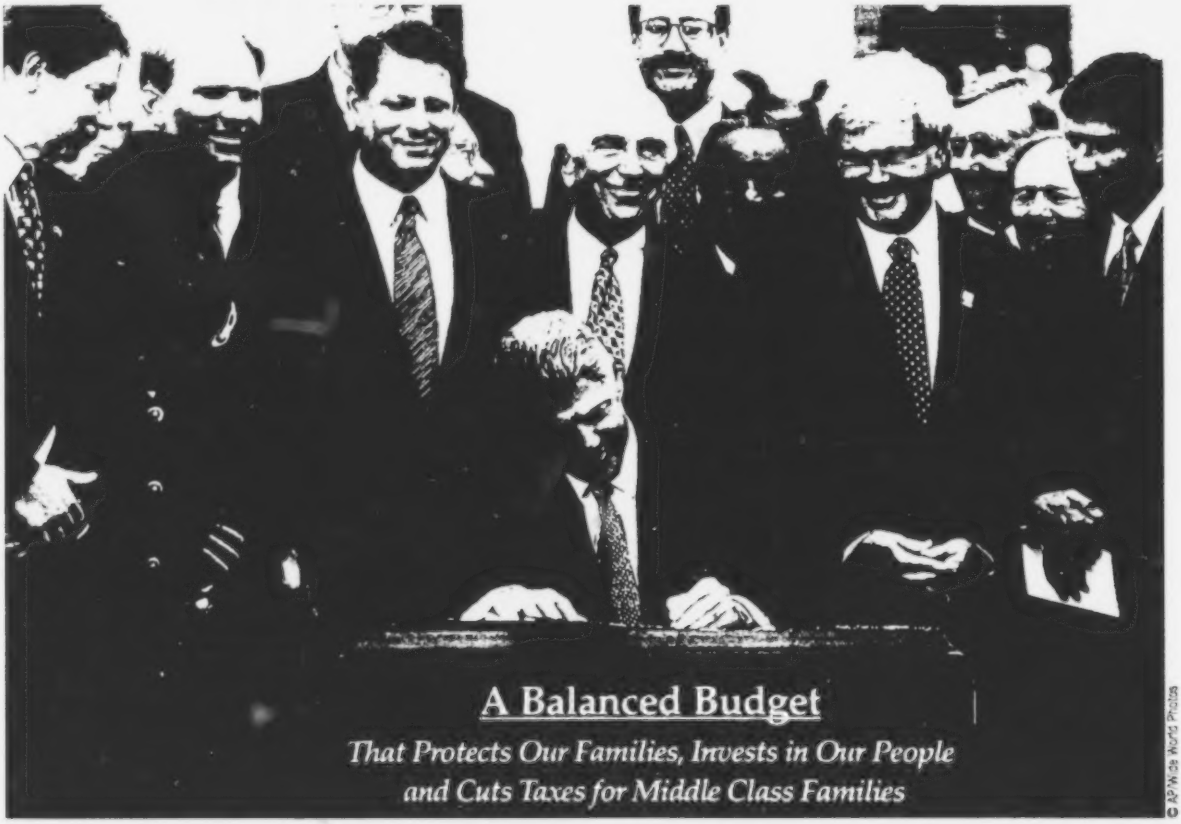


Source: Weigers, M.E., Weineck, R.M., and Cohen, J.W. *Children's Health 1996. MEPS Chartbook No. 1.* Rockville, MD: Agency for Health Care Policy and Research, 1998.

(TANF) block grant. In an attempt to assure that welfare changes would not result in the loss of Medicaid coverage, PRWORA severed the final eligibility link between Medicaid and cash assistance for families with children and replaced it with a new Medicaid eligibility category, referred to as Section 1931. Families with children now qualified for Medicaid on the basis of their income and resources, not on their status as welfare recipients.[20] Although implementation problems contributed to a decline in Medicaid coverage in the first years following welfare reform, PRWORA provided an important step forward in changing Medicaid from a welfare program into a health insurer for low-income families.

The delinking of Medicaid eligibility for children and their families from eligibility for welfare both increased the number of children covered and changed the composition of Medicaid beneficiaries. In 1975, 9.6 million children under age 21 were enrolled in Medicaid, and 88% of them were also receiving welfare assistance.[21] By 1995, 17 million children were enrolled in Medicaid, and just over half of them were receiving welfare.[22] In 1998, only 37% of children with Medicaid coverage were also receiving welfare.

Through a combination of incremental eligibility expansions, provisions to facilitate access to care, and the separation of health coverage from welfare, Medicaid made great progress in extending health insurance to low-income children in the United States. In its first three decades, the program evolved from an adjunct to an existing welfare program into the largest single insurer of children in the nation. Studies show that Medicaid's expanding role positively impacted the health status of American children.[23] Despite these advances, particularly for poor children and young children at incomes somewhat above poverty, coverage of near-poor children remained limited in many states. States had the option to extend Medicaid to children with family incomes beyond federal minimums and still receive federal matching funds, but as of 1997, less than one-third of states had taken this option.[24] Recognizing the effectiveness of public coverage and limits on its availability, policymakers and children's advocates began to explore how to further expand coverage.


A Balanced Budget
That Protects Our Families, Invests in Our People
and Cuts Taxes for Middle Class Families
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State Children's Health Insurance Program

In the aftermath of welfare reform and the failure to implement comprehensive health care reform in the mid-1990s, pressure grew to move incrementally to broaden coverage for at least children. Alternative strategies were debated: Some advocated expanding Medicaid to cover more low-income children, while others advocated a federal block grant that would give states virtually unlimited flexibility. The result was a compromise approach and the enactment in 1997 of SCHIP.

SCHIP provides $40 billion in additional federal financial support over 10 years to encourage states to offer coverage to uninsured children with family incomes above 1997 Medicaid eligibility levels. To assure that SCHIP funds would be used to extend coverage to currently uninsured children, the law included a number of provisions designed to prevent SCHIP from supplanting either employer-based coverage or Medicaid coverage.

The design of SCHIP reflects the fact that the legislation was the product of a political compromise between those advocating for a new health care block grant with little or no federal standards and those who supported a new Medicaid expansion for children. Unlike Medicaid, which provides open-ended federal financing, SCHIP is funded through a block grant—a capped amount of federal funds—that states can use to provide coverage to children. Like Medicaid, SCHIP requires states to contribute to the cost of care, but the federal government pays for a higher share of spending under SCHIP than under Medicaid (the "enhanced federal match" is 30% higher under SCHIP than under Medicaid).[25]

Though SCHIP was funded through a block grant, a compromise in the design of the coverage expansion allows states three options for structuring their programs: They may use their federal SCHIP funds to create or expand a separate child health program, expand Medicaid, or use a combination of both types of programs. As of July 2002, 16 states had elected to develop separate SCHIP programs with no Medicaid expansion, 16 states (including the District of Columbia) relied on Medicaid to expand coverage, and 19 states used a combination approach.[26]

States that choose to create separate child health programs generally have broad discretion in designing their programs. As part of the political compromise, however, states must cover a specified level of services and limit the costs that beneficiaries have to pay to receive those services (cost sharing). SCHIP requires that states' separate programs meet a "benchmark" benefit package, generally tied to a commercial plan available in the state or to the state employees' health benefit package. Cost sharing (including premiums, co-payments, and deductibles) must be nominal for children with incomes below 150% of poverty. For children in families with higher incomes, cost sharing must not exceed 5% of total family income. (See the article by Wysen, Pernice, and Riley in this journal issue.) In addition, in part because SCHIP does not provide open-ended federal financing, children have no federal entitlement to coverage under a separate SCHIP program. States can limit costs and coverage by capping or freezing enrollment at any time, even if a child meets the eligibility standards for coverage.

States that choose to use their SCHIP funds to expand their Medicaid programs must follow all Medicaid program rules, including those regarding benefits and cost sharing. Because Medicaid is an entitlement, and the state is required to enroll all children meeting the eligibility criteria, states may not cap or freeze enrollment under Medicaid expansions. Under both Medicaid and separate SCHIP program options, however, states can roll back or even eliminate their SCHIP-funded expansions at any time. If costs exceed the capped SCHIP allotment in a Medicaid expansion state, the state can use regular federal Medicaid matching funds to cover the additional costs.

SCHIP's passage in 1997 came at a fortuitous time. The economy was strong, and many states were experiencing revenue surpluses. The fiscal situation, the enhanced federal matching payments available under SCHIP, and the broad political support for children's coverage combined to make SCHIP-funded expansions almost irresistible at the state level. Every state took advantage of SCHIP and expanded coverage for children within the first two years of the program. The scope of coverage and program structure varies widely across the states, but nationwide, SCHIP has the potential to cover millions of low-income, uninsured children.

Health Coverage for Children after 1997

By 2000, Medicaid and SCHIP together covered 24 million children, with Medicaid covering 21 million poor and near-poor children, and nearly 3 million near-poor children assisted by SCHIP through either separate or Medicaid-operated programs. Medicaid and SCHIP had become the primary sources of health coverage for children from low-income families (those with incomes below 200% of the FPL, or $27,476 for a family of three in 2000): In 2000, 41% of low-income children were covered by Medicaid or SCHIP.[27]

The implementation of SCHIP was significant not only because it expanded eligibility to nearly all low-income children, but also because it ushered in a movement to get eligible children enrolled by addressing obstacles to coverage. Medicaid application and enrollment procedures were rooted in welfare application procedures. Long application forms with extensive questions and documentation requirements regarding work history, assets, and personal information; use of welfare offices and personnel for processing enrollment; and requirements of in-person interviews discouraged many applicants, particularly those who were not also applying for welfare, from initiating or completing the process.

Recognizing that the complexity and intrusiveness of the enrollment process often deters participation, many states sought to eliminate these barriers when designing their separate SCHIP programs. In the late 1990s, states developed short application forms, limited documentation requirements, streamlined the application process, and encouraged enrollment in SCHIP through outreach.[28] Over time, a growing number of states adopted these same simplification strategies in their Medicaid programs, dramatically improving the enrollment processes for children in Medicaid. The majority of states now use simplification strategies in both their Medicaid and SCHIP programs. Forty-four states have dropped the asset test for children's coverage, forty-seven states no longer require a face-to-face interview for children's coverage, and many states have eliminated most documentation requirements and renew coverage on an annual basis.[29,30]

Studies have examined whether these expansions have helped improve access to health care, reduce financial stress, and improve health outcomes for children.

Research studies consistently show higher levels of preventive care and greater likelihood of a usual source of care among children with public coverage compared with their uninsured counterparts (see Figure 2).[31] Among low-income children, research shows that public coverage through Medicaid is comparable to private insurance in securing access to care.[32] Medicaid coverage, and now SCHIP, helps give children a regular source of care and access to early preventive and primary care.

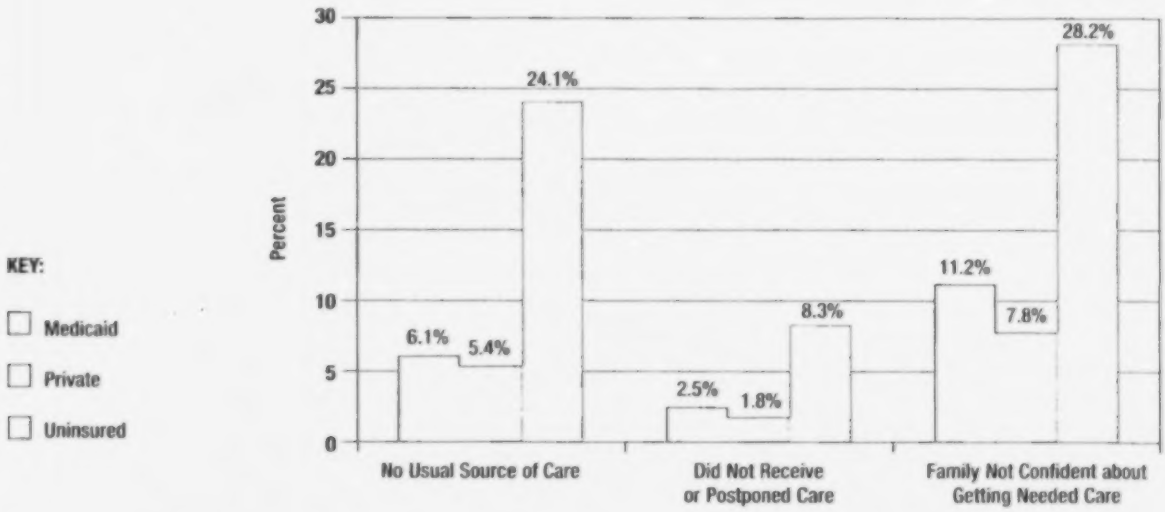
In addition, a growing body of evidence suggests that having insurance has a positive effect on health outcomes.[33] For example, Medicaid expansions were shown to reduce the number of acute health conditions, bed days, and restricted activity days among children.[34] As data and evaluations become available, comparable effects for children now covered by SCHIP who were previously uninsured may be documented. For example, an evaluation of the separate SCHIP program in Iowa (called Hawk-I) found that SCHIP coverage for children helped improve health status, reduce family stress, and promote access to care.[35,36] Ongoing research will provide additional evidence about the impact of these programs on children's access to health care and overall health status.

Current Challenges: Continuing the Progress

While Medicaid and SCHIP have created a strong foundation for providing health coverage to the nation's low-income children, an estimated 6.5 million low-income children remain uninsured.[37] (See the article by Holahan, Dubay, and Kenney in this journal issue.) This section discusses challenges facing public health insurance programs for children, including rising health care costs and falling state revenues, gaps in coverage, and remaining barriers to enrollment and retention of children.

Figure 2

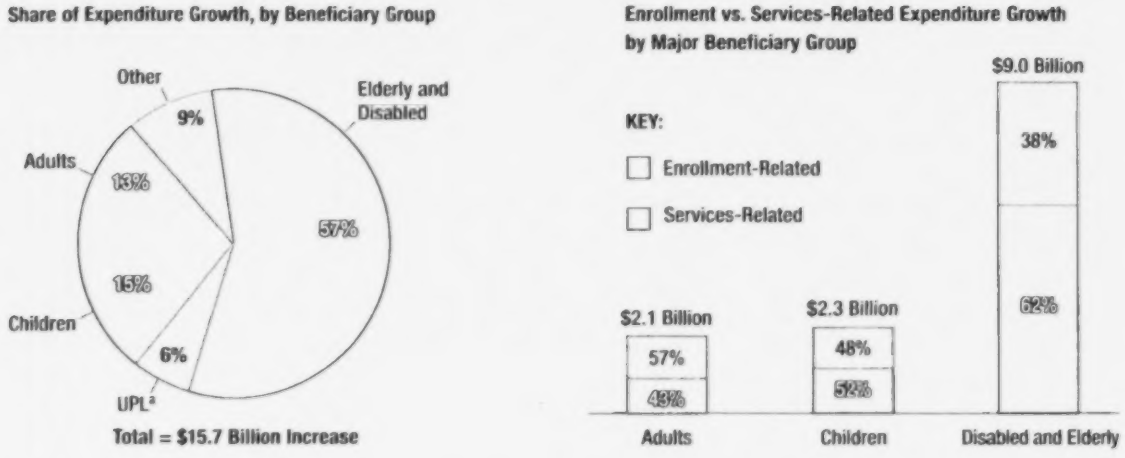
Access to Care among Low-Income Children by Insurance Status, 1997



Source: Dubay, L., and Kenney, G.M. Health care access and use among low-income children: Who fares best? *Health Affairs*, January/February 2001, Vol. 20(1), pp. 112–21.

Figure 3

Sources of Growth in Federal Medicaid Expenditures, 2001–2002



[a]UPL = Upper Payment Level

Source: Kaiser Commission on Medicaid and the Uninsured. Analysis of Congressional Budget Office Medicaid baseline data, March 2002.

Rising Health Care Costs and Falling Revenues

Just when the groundwork for covering all low-income children has been laid, and a blueprint for how to successfully identify and enroll eligible children has begun to emerge, fiscal pressures threaten to stall or even reverse this progress. The tasks of closing the gap between eligibility and enrollment and assuring that children receive the quality care they need once they are covered will be considerably more difficult in light of the downturn in the economy and rapidly rising health care costs. In an economic downturn, more children turn to Medicaid and SCHIP as their families lose income and health insurance coverage. Downturns, however, lower state revenues, making it more difficult for states to afford their share of Medicaid and SCHIP costs. Nationwide, state tax revenues are falling more sharply than they have in more than 10 years.

Adding to the problem of greater need and lower revenues is the rising cost of health care services. The cost of private health insurance premiums is climbing at a rate of 11% to 12% per year.[38] Medicaid spending is growing at rates that are similar although not quite as steep. In March 2002, the Congressional Budget Office estimated that federal Medicaid costs would grow by an average of 9% per year between 2001 and 2012.[39] Although, as shown in Figure 3, children's coverage is not a major driver of these cost increases, all spending is subject to reexamination when states face large budget shortfalls.

In Medicaid, federal financial support grows as costs and enrollment increase, but states may need even greater assistance from the federal government to avert cutting back on coverage and care. Federal SCHIP funds are capped, and while federal caps and related SCHIP financing rules do not pose an immediate threat to children's coverage, unless some changes are made, several states will hit those caps over the next few years. According to projections by the federal Office of Management and Budget, this situation could lead to the loss of coverage for nearly 1 million children.[40]

Remaining Gaps in Coverage

These fiscal challenges make it even more difficult to address remaining gaps in coverage. Although most low-income, uninsured children are now eligible for coverage through Medicaid or SCHIP, some poor and near-poor children still do not qualify for coverage due to limits on income eligibility in some states and limits on coverage of immigrants. In addition, many parents of children who are eligible for Medicaid and SCHIP are themselves uninsured. Coverage gaps for children and parents might also widen if a weakening economy and fiscal pressures push states to roll back eligibility standards for children, freeze enrollment in separate SCHIP programs, or impose premiums for children that may be difficult for their families to manage.

Immigrant Children

As considered more fully in the article by Lessard and Ku in this journal issue, legally present immigrant children who entered the United States after August 1996 are generally barred from Medicaid and SCHIP for their first five years in the country, regardless of their income. Over time, the ban will affect a growing number of children who are in the country legally. In addition, undocumented children have always been barred from enrolling in Medicaid, except to receive emergency services.

The five-year ban creates barriers to care and adds to the fiscal pressures facing state and local governments and safety net institutions. Children who are not eligible for public health coverage because of their immigrant status are more likely to be uninsured and thus less likely to receive the health care they need.[41] If they do receive care, it is often because either state or local government is paying the cost of that care without the benefit of federal payments, or local safety net institutions are bearing the burden without any direct reimbursement. Either way, ongoing care for these children is at risk, particularly in light of pressure to cut services that do not qualify for federal matching payments from state budgets and the fiscal stress that most safety net providers are experiencing.

Family Coverage

Many parents of children eligible for Medicaid and SCHIP are uninsured. In light of research showing that family coverage improves opportunities to enroll children and helps assure that they will get needed services, efforts to extend coverage to children in low-income families have focused attention on covering parents as well.[42]

In contrast to the policies that apply to children, there is no uniform federal eligibility standard for Medicaid coverage of parents, nor is there a consistently available source of enhanced federal matching payments to help states expand coverage to parents. The delinking provisions adopted by Congress in 1996 offer states new options to broaden coverage for low-income parents, and many states have taken advantage of these options, at least until the most recent economic downturn. In addition, some states have obtained waivers to federal rules that enable them use of SCHIP funds to lower the state cost of covering parents.[43] Not all states, however, have available SCHIP funds to redirect to parents.

As shown in Figure 4, parents' coverage standards in most states remain below the FPL and well below the standards for children. As of July 2002, only 18 states covered parents with earnings at or above the FPL. In 13 states, parents with incomes at 50% of the FPL are "over income" for Medicaid. Two states (Missouri and New Jersey) that had covered parents up to or above the FPL rolled back that coverage in the summer of 2002 because of state budget pressures.[44] As a result of low Medicaid eligibility levels for parents and limited opportunities for low-wage workers to obtain employer-based coverage, one out of every three low-income parents was uninsured in 2000.[45]

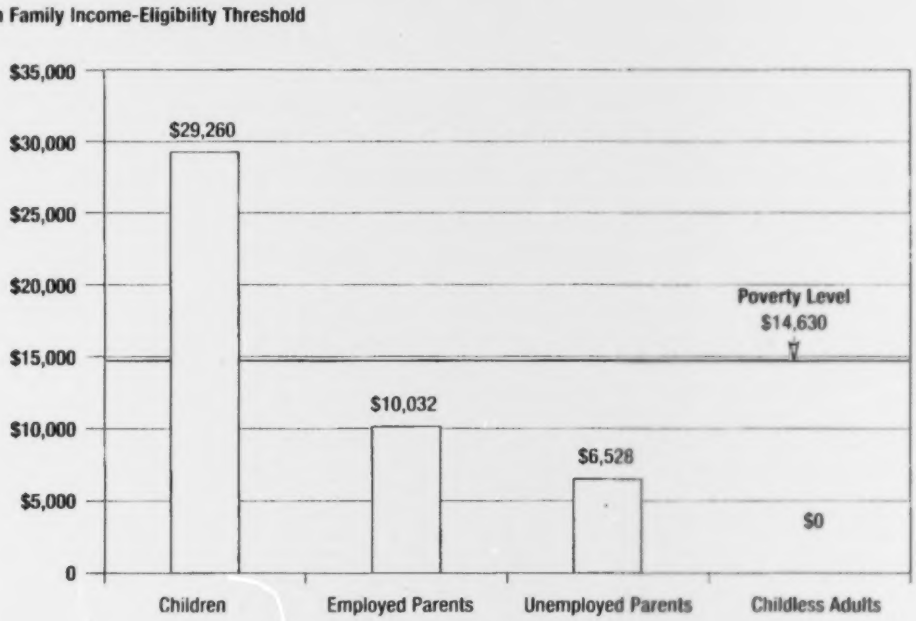
Eligibility Rollbacks, Enrollment Caps, and Premiums

Because separate SCHIP programs are not entitlement programs for children, states can stop enrollment and create waiting lists for coverage. Shortfalls in state funding for SCHIP have already prompted freezes in enrollment in some states. As of August 2002, three states (Montana, North Carolina, and Utah) stopped enrolling children in their separate SCHIP programs for some period of time. Several other states have imposed caps on the number of children they will enroll (or on the amount of dollars they will spend), but they had not reached those caps and had not stopped enrolling children in SCHIP. A preliminary analysis of families affected by the enrollment freeze imposed in North Carolina in 2001 shows that the enrollment cap caused parents to delay necessary care for children and imposed considerable debt on low-income families.[46]

Because Medicaid is an entitlement, states may not cap enrollment in their Medicaid programs, at least not without special permission from the Secretary of Health and

Figure 4

Income-Eligibility Thresholds for Children and Parents under Medicaid and SCHIP, 2001



Note: Based on a family of three. The eligibility threshold for working parents takes into account states' earnings-disregard policies, while the threshold for children does not.

Source: Guyer J. Low-income parents' access to Medicaid five years after welfare reform. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002, p. 5.

Human Services (obtained through a waiver of federal Medicaid rules). While some states have been granted waiver authority to cap enrollment for adults (including parents), no state had a waiver that would allow an enrollment cap for children.[47]

States can roll back their eligibility standards in either Medicaid or SCHIP without a waiver, however, as long as they continue to cover children who fall below the federal Medicaid minimum eligibility standards. Rollbacks, like enrollment freezes, reduce the coverage available to children, but they do so based on family income rather than on a first-come, first-served basis. While a few states considered rolling back children's eligibility under SCHIP and Medicaid as they prepared budgets for 2003, no state had actually taken that step as of June 2002.[48] Yet, budget analysts and state Medicaid agencies predicted that many states would have to revisit their 2003 budgets soon into the year to address shortfalls.[49] It remains to be seen whether the eligibility standards for children that were in place in 2002 will represent the high-water mark for children's coverage, at least for the next several years.

In addition to eligibility rollbacks and enrollment caps, coverage may be at risk if budget pressures prompt states to impose premiums that are difficult for some families to manage. In the absence of a waiver, states cannot charge premiums for children's coverage in Medicaid (except for families with children who are eligible under the "transi-

The vast majority (84%) of the nation's 6.5 million low-income, uninsured children are now eligible for public coverage.

tional medical assistance" coverage category. See Box 1, DEFRA provisions). Premiums for children are allowed under SCHIP, within federal guidelines. Over the past year, as a result of budget pressures, a few states have imposed new premiums or increased premiums for children in both Medicaid and SCHIP.[50] Research has shown that premiums will reduce participation rates among low-income people, but it is too early to know whether the new premium charges will impose too heavy a toll on low-income families and reduce participation among otherwise eligible children.[51]

Promoting Enrollment and Retention of Eligible Children

The vast majority (84%) of the nation's 6.5 million low-income, uninsured children are now eligible for public coverage, according to analyses based on 2000 state eligibility levels. Most (60%) are eligible for Medicaid, and 24% are eligible for SCHIP (either through separate SCHIP programs or through SCHIP-funded Medicaid expansions).[52] While much progress has been made in promoting enrollment of eligible children in recent years, continued efforts will be needed to eliminate remaining barriers to enrollment and retention and to coordinate enrollment between Medicaid and separate SCHIP programs.

Removing Barriers to Coverage

Barriers to enrollment and retention, including a lack of information about eligibility, have been long-standing problems in Medicaid. Some of these problems, particularly in the area of retention, have arisen in SCHIP as well. However, strategies adopted by many states to improve participation rates in public programs have demonstrated that both SCHIP and Medicaid can be designed to encourage enrollment and retention, consistent with federal rules.[53] (See the article by Cohen Ross and Hill in this journal issue.) Nonetheless, although the policy levers are in place, several states still have more burdensome procedures in Medicaid than in SCHIP, and many states have not carried over to family applications and renewals all the simplification strategies implemented for children.

Eligibility renewals continue to pose a challenge to assuring continuity of coverage, and they create a risk point where eligible children often lose their coverage.[54,55] Moreover, some children and families experience difficulty in keeping their Medicaid coverage when they leave welfare. An estimated 1.7 million children lost Medicaid coverage as a result of welfare reform, and many of the children who lost Medicaid (50%) were uninsured.[56] The Medicaid/TANF delinking issue received a good deal of attention in 1999 and 2000 and resulted in considerable efforts by states to remedy the problems that had been identified.[57] Yet, some problems may still be unresolved. Nationally, enrollment of children in regular (non-SCHIP) Medicaid has rebounded after declines following the enactment of the 1996 welfare law, but there are significant variations across states, suggesting that problems may persist in some states.[58]

Over the next few years, state and local delinking systems will face a new test. TANF rolls have risen in many states as a result of the downturn in the economy, but when the economy picks up again, families will find jobs and leave welfare. In addition, over the next few years, more children will be reaching their TANF time limits (the five-year maximum that their families may receive cash assistance). Effective and updated automated eligibility systems, staff training, and continued efforts to inform families of continued Medicaid eligibility will help prevent the loss of Medicaid or SCHIP among eligible children whose TANF benefits end.

Creating Seamless Systems of Coverage

Two-thirds of the states now have two separate publicly funded health coverage programs for low-income children: Medicaid and SCHIP. The other states have Medicaid expansion SCHIP programs. Unless the two programs function effectively as a unified system of providing coverage for children, children will inevitably fall through the cracks, and states will fall short of their coverage goals.

Families often do not know if their children are eligible for Medicaid or for SCHIP. Without coordination at the enrollment stage, children applying for the "wrong" program could be left uninsured. Similarly, children cross in and out of eligibility for Medicaid and SCHIP because their family circumstances tend to be fluid. In some

states, because eligibility rules are tied to a child's age, children must transfer from Medicaid to SCHIP when they "age out" of Medicaid, even with no change in their family circumstances.

Without systems that assure seamless transitions between programs at the application and renewal stages, normal life-cycle changes will put continued coverage of eligible children at risk. Limiting the instances when a program transfer requires families to switch providers can promote continuity of care. For some families, the need to change providers can be the most negative aspect of a transition between coverage programs.[59]

Coordinating Public and Private Coverage

States face a number of challenges as they look to coordinate public and private coverage. In the past few years, a number of states have pursued ways to use SCHIP and Medicaid funds to purchase employer-based coverage and in some cases also to purchase coverage available on the individual market. The goal is to promote reliance on private coverage systems and in some cases to reduce public costs. Medicaid rules allow states to subsidize private coverage if states find it cost-effective to do so, but SCHIP rules are more limited, in part because of the concern, when SCHIP was created, that subsidies for employer coverage would result in employers pulling back their contributions (referred to as "crowd-out"). A few states administer premium-assistance programs, but in general enrollment has been quite limited, largely because so few low-income families have access to employer-based coverage. (See the article by Curtis and Neuschler in this journal issue.)

Premium-assistance programs are strongly favored under the Bush administration's Health Insurance Flexibility and Accountability (HIFA) waiver initiative. According to administration guidance, all HIFA waivers must have a premium-assistance component. Already, several states have applied for waivers or have had waivers approved to subsidize private coverage with Medicaid and SCHIP funds. These waivers generally do not assure children supplemental coverage to bring cost sharing and benefits up to the minimum Medicaid or SCHIP federal standards. It remains to be seen whether these efforts will prove to be a cost-effective way to deliver coverage that meets low-income children's needs.

Improving Access to Care

Enrollment is only the first step to receiving care. Benefit packages and access to doctors, hospitals, and other health care providers are critical components of the children's coverage story.

Benefits

Now that initial implementation of SCHIP is over, the scope and quality of the care that children receive once they are enrolled in SCHIP and Medicaid are attracting more attention. The scope of benefits offered to children under Medicaid and separate SCHIP programs can differ substantially under the rules established by federal law, although in many states the benefit packages are quite similar.[60] Budget pressures, however, may result in fewer benefits being available through both programs.

As described previously, Medicaid EPSDT rules are intended to assure that poor and near-poor children eligible for Medicaid receive regular preventive care, health screenings, and all necessary treatment. While questions about the cost of EPSDT arise periodically, children covered under Medicaid continue to be the lowest-cost group of Medicaid beneficiaries.[61] In some cases, because of low provider rate payments, states incur fewer costs covering children in Medicaid than in separate SCHIP programs, even though federal SCHIP rules do not require states to provide EPSDT to children.[62] Nonetheless, budget pressures and new waiver policies at the federal level will inevitably focus renewed attention on EPSDT. For example, Tennessee, a state facing budget shortfalls and long-standing problems ensuring that its managed care organizations actually delivered EPSDT services, recently obtained a waiver from the federal government eliminating the EPSDT requirement for children covered at state option.[63]

Separate SCHIP programs do not have to comply with EPSDT requirements, but many states have adopted benefit packages that are broader than typical commercial plans.[64] In other states, benefits provided under separate SCHIP programs are more limited in scope,[65] raising questions about how well children with mental health problems and special health care needs are faring in separate SCHIP programs.[66] Estimates suggest that as many as 17% of children eligible for SCHIP

Limited access to providers willing to see Medicaid patients has intermittently plagued the Medicaid program since its inception.

have disabilities or chronic illnesses.[67] Some states, such as Connecticut and North Carolina, have addressed the needs of these children by offering supplemental coverage to children with special health care needs. One of the challenges facing states, however, is effectively identifying these children so that they are able to get the care they need.[68]

To the extent that states are providing benefits in separate SCHIP programs that exceed federal minimum standards, budget pressures may result in benefit reductions. At least one state (Utah) eliminated dental services for children in its separate SCHIP program in 2002 as a result of fiscal constraints. In addition, as mentioned previously, fiscal pressures are prompting some states to increase the amount families must pay through co-payments and coinsurance requirements to access services under SCHIP. Although cost sharing is not allowed for children under Medicaid, a few states are seeking waivers that would allow them to impose such costs. Cost sharing by families may reduce the state and federal costs of providing Medicaid and SCHIP and allow states to keep benefit packages intact. However, cost sharing also can interfere with children's access to care, depending on the costs imposed and the income level of families who are required to pay them.[69]

Access to Providers

Limited access to providers willing to see Medicaid patients has intermittently plagued the Medicaid program since its inception. Several factors contribute to provider access problems, including the lack of certain types of providers in some parts of the country and relatively low provider payment rates. The American Academy of Pediatrics has identified low provider rates and burdensome paperwork imposed on providers as the two main reasons for low rates of pediatrician participation in Medicaid.[70] Similarly, the federal Centers for Medicare and Medicaid Services (which oversees the Medicaid program at the federal level) has noted a link between low provider payment rates for dentists and limited access to children's dental services.[71] Limited information is available concerning the adequacy of providers for children enrolled in separate SCHIP programs.

Budget pressures at the state level threaten to worsen provider access problems. In a preliminary review of state budget actions taken in Medicaid and SCHIP in their Fiscal Year 2003 budgets, 28 states reported that they were cutting or freezing their Medicaid provider payment rates. Hospitals, physicians, nursing homes, and managed care organizations were most heavily affected by these rate changes.[72] Co-payments and coinsurance charges also could affect provider participation in Medicaid because providers often view these charges as reductions in Medicaid or SCHIP payment rates. In July 2002, one of the largest drugstore chains in Massachusetts, reportedly serving one-third of all Medicaid beneficiaries in the state, threatened to withdraw from the Medicaid program, largely because of rate cuts and new Medicaid and SCHIP pharmacy co-payments imposed by the state.[73]

Federal Financing Issues

In light of state budget pressures and the "dip" in federal SCHIP funding that was built into the original authorization of the program, federal financing issues could have a profound effect on states' ability to continue to provide coverage and a broad set of benefits to low-income children. Still unknown is the extent to which SCHIP waivers that redirect SCHIP spending to other populations will impact children's coverage.

The SCHIP "Dip"

In the formula for distributing SCHIP funds, there is a mismatch between the timing of the availability of federal funds and states' need for those funds. SCHIP was enacted at the same time Congress was trying to reach its balanced-budget goals at the federal level. As a result, the total amount of federal SCHIP funding dropped in 2002 and will not reach its pre-2002 levels until 2005. The drop in funding came after the initial SCHIP start-up period, when enrollment was growing at a strong pace.

The dip in federal SCHIP funds prompted the federal Office of Management and Budget to project a significant decline in SCHIP enrollment beginning in federal Fiscal Year 2004 (see Figure 5). (The lag in the impact of the dip stems from the fact that states have three years to spend their SCHIP funds; carryovers will help most states keep enrollment intact for a few years after the dip

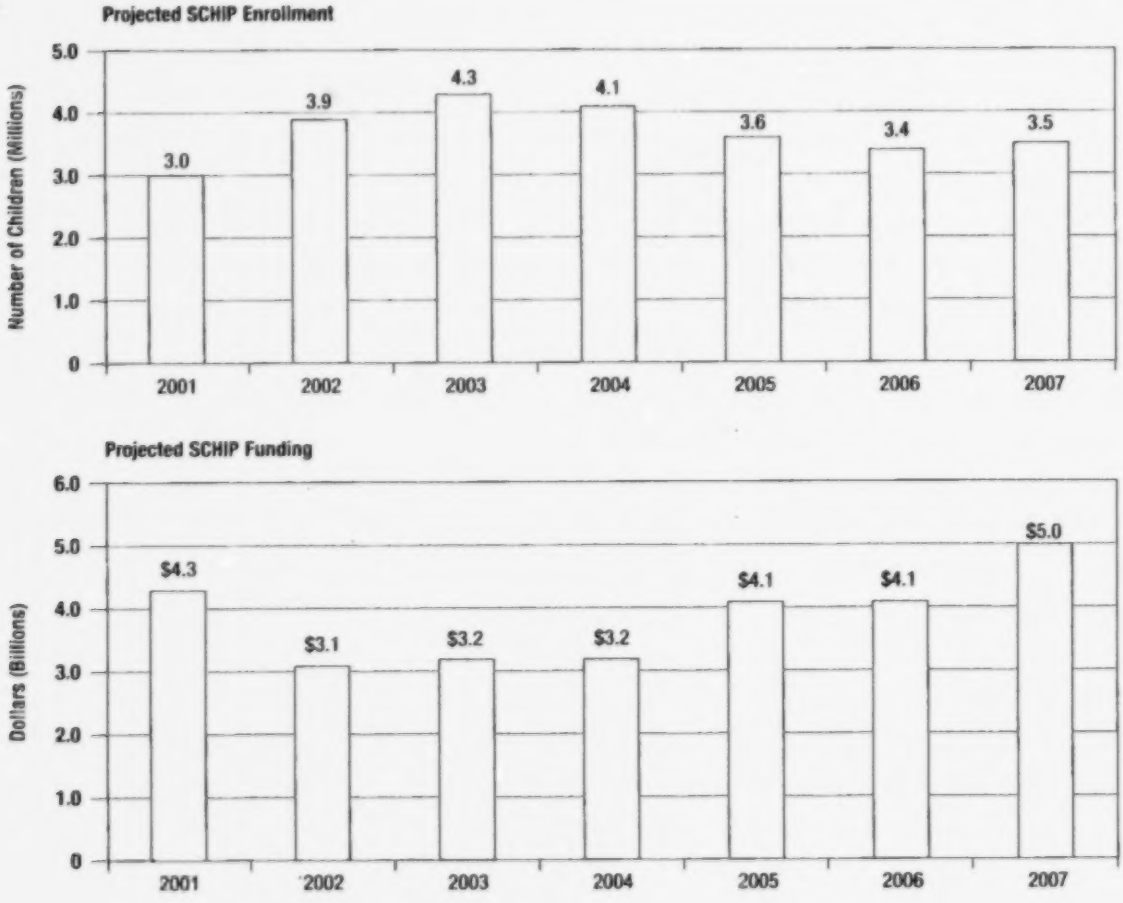
begins.) SCHIP funds that were unspent in the program's early years (Fiscal Years 1998 and 1999) could have helped address this dip, but under SCHIP funding rules, these funds reverted to the Treasury (that is, became unavailable to states to cover children) at the end of federal Fiscal Year 2002.

SCHIP Waivers

SCHIP waivers will also impact SCHIP funding, although it is difficult to predict the extent of the impact. As noted above, waivers have allowed states to use SCHIP funds to cover populations other than children. In July 2000, federal waiver policy allowed states to use SCHIP funds to

Figure 5

Projected SCHIP Enrollment and Funding, 2001–2007



Note: Office of Management and Budget SCHIP projections are based on average annual enrollment.

Source: Office of Management and Budget. Analytical Perspectives, Budget of the United States Government, Fiscal Year 2003. Table 15-3, p. 297.

cover parents and pregnant women under certain circumstances.[74] This policy was expanded under HIFA guidelines announced in August 2001.[75] Under HIFA guidelines, states may use SCHIP funds to cover childless adults as well as parents and pregnant women.

These waiver opportunities may help states expand coverage or maintain current coverage for low-income adults. Because SCHIP funds are capped overall, however, waiver spending will reduce the amount of funds some states might receive to cover children. Under the SCHIP funding formula, SCHIP funds that are unspent after three years are reallocated to other states that have fully spent their SCHIP funds. (States have one year to spend the reallocated funds. At the end of the year, the funds revert to the Treasury.) More waiver spending will result in less money moving to other states through the reallocation process. The extent to which SCHIP waiver policy affects children's coverage will depend on many factors, including the level of SCHIP waiver activity in the states, states' needs for SCHIP funds to cover children, and whether federal legislation restores the funds that reverted to the Treasury and addresses the dip in federal SCHIP funds.

Medicaid Financing

Federal Medicaid funds are the largest source of federal grants to states, accounting for 42% of all federal grants to states in 2000.[76] However, given the fiscal pressures faced by states generally and in their Medicaid programs particularly (because of rising health costs), states are looking to the federal government to increase the level of federal financial participation in Medicaid, at least for as long as the economic downturn continues.[77] In the long term, policymakers may need to consider whether it makes fiscal or policy sense to have a higher federal matching rate for the children states cover through SCHIP than for the children states cover through Medicaid. Greater levels of federal financial support for children's coverage could be made available to states by raising the matching rate for children in Medicaid to the higher SCHIP matching rate.

Lessons Learned

Despite the challenges that remain and the strains likely to occur with a weaker economy, Medicaid and SCHIP together provide an important vehicle for providing coverage to many of the nation's low-income children. Experience with the recent expansions in publicly sponsored coverage shows that families value coverage, but efforts are needed to inform them about available coverage and allow them to access that coverage without undue burden.[78] The recent experience with expansions in coverage for children also shows that reliable, substantial federal financial participation and federal coverage standards are critical to efforts to close coverage gaps. The steady growth in the number and percentage of children covered by Medicaid from the mid-1980s until welfare reform, in contrast to the decade before, reflects the availability of federal matching funds for expansions in children's coverage as well as the influence of federal requirements. In the absence of federal standards, many children would have remained uninsured, and coverage would have varied markedly across states. For example, while states had the option to cover pregnant women and infants with family incomes up to 133% of the FPL before 1990, 31 states did not expand coverage up to this income level until federal law made it a requirement in April 1990.[79] The recent experience with SCHIP shows that in a strong economy, enhanced federal funding can boost coverage considerably above federal requirements. (See Box 2 for a state and federal perspective on lessons learned from SCHIP.) The impact of a weakening economy and rising costs on state coverage options, even with an enhanced matching rate, remains to be seen.

While it is clear that predictable and substantial federal funding is critical to children's coverage, it is not clear how the differences between the Medicaid and SCHIP financing systems will affect coverage over time. SCHIP and Medicaid offer two distinct models of financing. In Medicaid, federal dollars follow the beneficiary. If more children are enrolled, more federal funds are automatically available to the state to help cover the cost of the coverage. Then, if per-child costs rise for any reason, more federal dollars are automatically available to share those added costs. This open-ended financing system allows the program to operate with certain guarantees: Children are guaranteed coverage as long as they meet the state's eligibility rules; providers are guaranteed payment for services rendered; and the state is guaranteed its federal share of all Medicaid expenditures.

By contrast, the federal government's commitment under SCHIP is capped, and the amount of funds any state will receive is difficult to predict, given that some portion of a state's federal funding depends on how much other states

Box 2

Views from Debbie I. Chang: A Federal and State Perspective

Within the last 20 years, child health policy in this country has dramatically evolved, fueled by innovations at the state level and by federal actions to modify the existing federal and state frameworks for Medicaid. In 1997, major national policy decisions were made regarding children's health, when the SCHIP program was established. The following observations reflect lessons learned from the perspective of Debbie I. Chang, who has worked on child health policy at the federal and state levels for the past 15 years. She led the implementation of SCHIP in 1997 at the Centers for Medicare and Medicaid Services and is now the Medicaid and SCHIP director for the state of Maryland.

- **Program eligibility rules should be simple to maximize coverage and ease administration.**
  Under SCHIP, states have worked to make eligibility more uniform, and usually based on income, rather than welfare rules. Together with reforms to simplify Medicaid, SCHIP has almost eliminated Medicaid's complex system of providing eligibility for categories of children and women.

- **Simplifying the enrollment process and undertaking proactive outreach increases enrollment.**
  SCHIP demonstrated that simple, short application forms that could be mailed in, coupled with local outreach efforts that target locations with many children, such as children's day care centers and schools, were effective at increasing the enrollment of eligible children.

- **New and established programs benefit from and influence each other—yet their structures differ according to the populations they serve.**
  The simplification of enrollment under SCHIP has influenced Medicaid's enrollment processes. States have dropped Medicaid asset tests and face-to-face interviews and simplified Medicaid documentation requirements under Medicaid. Yet, Medicaid's administrative infrastructure (including its management information systems, quality-of-care mechanisms, and provider base) created a strong platform for launching SCHIP programs.

  Program design also differs according to the income levels of the populations served. Programs that cover children in very poor families must respond to greater health care needs and limited family resources with comprehensive benefits (such as the current Medicaid benefits). But, as families with higher levels of income are covered, states need the flexibility to design coverage that is similar to that found in the private sector. The mechanisms to subsidize private insurance coverage also need to be simplified.

- **Despite some inherent tension, the federal–state partnership works effectively to improve health for children.**
  The arrangement of providing federal funds to match state investments provided opportunities and incentives for states to expand coverage. The federal government's broad parameters also gave states the flexibility to develop programs that addressed their unique needs. At the same time, enhanced federal matching resulted in more focused attention where virtually all states created new programs. Federal standards also set the framework for state choices on designing programs, while enhanced federal matching compensated for additional federal requirements.

- **Incrementally building on current programs is cost-effective, but results in equity issues.**
  States provided different levels of health coverage to low-income children under their Medicaid programs. When new funding came available under SCHIP, states that already covered children at higher levels of poverty did not benefit as much from higher levels of federal funding. In addition, because of the focus on the currently uninsured, families who had already purchased coverage for their children or were underinsured did not benefit.

- **Accurate baseline data is needed to monitor success and improve accountability.**
  Limitations of the data available on the number of uninsured children mean that states do not have good baseline data. This makes it difficult to determine how effectively the program has reduced the numbers of uninsured children because states do not have accurate baselines.

- **Implementing new programs takes time, and expectations should be realistic.**
  SCHIP was enacted in August 1997, and the money became available to states with approved plans less than two months later. Soon after SCHIP was implemented, issues of how many children were enrolled were raised. Now, after four years, the number of children ever enrolled increased to 4.6 million in Fiscal Year 2001. Federal and state governments need time to systematically develop policies and design effective programs.

have spent. In part because federal financing is capped, SCHIP does not provide children with an entitlement to coverage, and while the capped funding is less advantageous to states, some states were attracted to SCHIP precisely because it did not involve an entitlement. Given the relatively short life of SCHIP, it is too soon to know how these features will affect states' willingness and ability to sustain coverage, maintain provider participation, and assure children's access to care.

The evolution of children's coverage through Medicaid and SCHIP also underscores the importance of designing programs for low-income children that recognize their health needs (which are often greater than those of their higher-income peers) and their families' limited resources. For poor and near-poor children covered under Medicaid, EPSDT provides services beyond the coverage available in typical employer-based health plans at no cost to the family. Most children do not use a high level of services, but some children need these services. Through SCHIP's extension of coverage to children in low-income families with incomes above Medicaid levels, the scope of benefits and appropriateness of cost sharing and premiums were reassessed. As different states try different approaches, they will undoubtedly learn more about how to design and implement health insurance programs that meet the needs of a broader group of low-income children.

The path to improving coverage for children has not been smooth, however, and many challenges are still ahead. Medicaid has struggled with developing its own rules and procedures, separating from welfare, and bringing the public's perception of the program in line with its new role. SCHIP has had to survive unrealistic expectations that millions of children would be enrolled during the first year or two in operation, and states must contend with SCHIP block grant financing that may not fully respond to enrollment trends and coverage demands among children. Both programs have contended with a changing marketplace, rising health care costs, and, more recently, an economic downturn.

Publicly funded coverage for children through Medicaid and SCHIP fills a critical void in the patchwork health care system in the United States. With one out of five children enrolled in these programs, and more children eligible, public coverage has made and will undoubtedly continue to make a large contribution toward the goal of providing all children with health coverage and access to health care. Reaching children who are eligible for assistance, but remain uninsured, extending coverage to their families, and maintaining meaningful coverage for children and families who are enrolled are the most significant future coverage challenges.

The author Cindy Mann was a senior fellow at the Kaiser Commission on Medicaid and the Uninsured while writing this article.

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11. In 1989, the EPSDT provision was further amended to require states to provide treatment services for problems discovered during EPSDT screenings, as long as the treatment involved services that could be covered under federal Medicaid rules.

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Which Children Are Still Uninsured and Why

John Holahan, Lisa Dubay, and Genevieve M. Kenney

SUMMARY

A strong economy and increased enrollment in employer-sponsored health insurance coverage, together with expansions in Medicaid and State Children's Health Insurance Program (SCHIP) led to reductions in uninsurance among low-income American children between 1998 and 2000 (from 15.6% to 13.3%). Nonetheless, 12% (about 9 million) of children remained uninsured. Identifying these children and understanding the factors that contribute to their continued lack of health coverage is key to providing them access to health care.

Using 1994, 1998, and 2000 census data, this article analyzes recent trends in children's health coverage, as well as the groups that make up the population of uninsured children. The picture that emerges from these analyses is one of tremendous variation in coverage for different groups of children, with some groups having a higher risk for lacking health insurance. For example, poor children, Hispanics, adolescents, and children with foreign-born parents (particularly those whose parents are not U.S. citizens) are overrepresented among the uninsured.

The authors conclude that the strong economy and concomitant increase in employer-based coverage played a bigger part in reducing uninsurance rates than did expansions in public programs. They also argue that lack of participation by eligible children rather than inadequate eligibility levels is the key policy issue, and conclude with several recommendations to increase program participation.

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The late 1990s saw an unprecedented federal and state commitment to reducing uninsurance among children, which culminated in 1997 with the enactment of the State Children's Health Insurance Program (SCHIP). The period also witnessed an unparalleled economic boom. Even so, 9.2 million children—12% of all children nationwide—were uninsured in 2000.[1] Given the adverse consequences of going without insurance[2-4]—such as a lower likelihood of having a usual source of care, greater unmet health and dental needs, lower receipt of preventive services, and higher rates of avoidable hospitalizations (see the article by Hughes and Ng in this journal issue)—the lack of insurance coverage for children is a serious problem in this country.

This article sheds light on why so many children remain uninsured in spite of Medicaid and SCHIP programs, which could cover 65% to 75% of all uninsured children, and a period of great economic prosperity.[5] It begins with an analysis of recent trends in children's health insurance coverage,[6] and an analysis of the population of uninsured children. These analyses suggest that specific groups of children will need to be targeted if major inroads are to be made in reducing uninsurance among children. The article closes by discussing the major policy changes needed to increase the participation of currently unenrolled children.

Recent Trends in Children's Health Insurance Coverage

Children's insurance coverage is influenced by a host of factors, including access to public and private coverage, and the sociodemographic characteristics of children and their families.[7-9] The 1990s were characterized by a number of shifts in these underlying factors that combined to produce a decline in the rate of uninsurance among children, from 14.5% in 1994 to 13.3% in 2000.[10] The primary factor in this decline, however, was the large increase in employer-sponsored insurance (ESI) coverage of children, not expanded access to public insurance programs. Moreover, the decline would have been even greater if not for two important demographic changes: growth in the share of children who are Hispanic or "other" race/ethnicity, and growth in the percentage of children age six and older. Because these groups have higher rates of uninsurance, as the number of children in them increased, more children were at risk of not being covered.

Shifts in Reliance on Public and Private Coverage

Between 1994 and 2000, ESI coverage of children expanded from 60.5% to 65.1%—an increase of 5.1 million children covered through employers (see Figure 1). Over the same period, Medicaid and SCHIP (including other state coverage) declined from 18.5% to 16.4%, a reduction of 1.1 million covered children. Coverage through federal programs such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Medicare and coverage in the private nongroup market also declined. The increases in ESI were more than sufficient to offset the declines in public and nongroup coverage, so the uninsurance rate fell. However, the number of uninsured children fell by only 500,000 because of the growth in the overall number of children during these years.

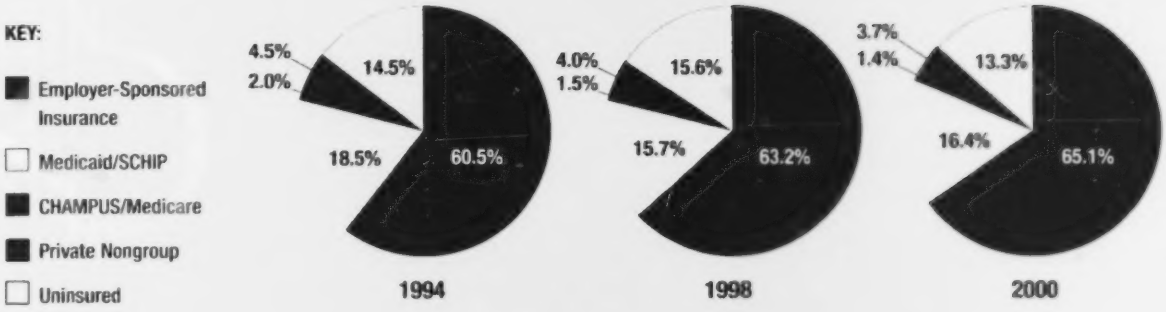
These shifts were spurred by three significant events: the strong economy, welfare reform, and implementation of SCHIP. The economy emerged from a recession in the mid-1990s and underwent a period of strong expansion as the decade wore on. Periods of economic growth tend to be associated with lower unemployment and rising incomes, which generally lead to greater access to private coverage. Between 1994 and 2000, the strong economy did, in fact, spur increases in ESI.

At the same time, the enactment of federal welfare reform legislation in 1996 may have had unintended consequences for Medicaid enrollment,[11] particularly in 1997 and 1998, when the new law was first being implemented. Medicaid and state coverage declined sharply as many families moved off welfare. Some families were taking advantage of new job opportunities and gained access to ESI. Overall, however, in the four years between 1994 and 1998, more children became uninsured than gained access to private coverage, so that the percentage of uninsured children increased from 14.5% to 15.6% (an increase of 1.2 million children).

In the next two years, 1998 to 2000, the economic boom continued and the rate of ESI for children continued to increase, from 63.2% to 65.1%. In addition, SCHIP programs were launched, and more efforts were made to

Figure 1

Children's Health Insurance Coverage



Source: Urban Institute, 2001. Based on data from March Current Population Surveys, 1995, 1999, 2001.

minimize the effects of welfare reform on Medicaid. SCHIP increased the eligibility thresholds at which children could qualify for public coverage, resulting in substantial expansions in public coverage. (See the article by Mann, Rowland, and Garfield in this journal issue.) While initial participation rates were lower in SCHIP than in Medicaid, more recently, SCHIP enrollment has increased substantially. At the same time, because of federal oversight and pressure from advocates, states responded to the decline in Medicaid coverage associated with welfare reform by improving their enrollment procedures, and Medicaid coverage also has increased. (See the article by Cohen Ross and Hill in this journal issue.)

These eligibility expansions led to a small but statistically significant increase in Medicaid and SCHIP coverage, from 15.7% in 1998 to 16.4% in 2000. Other government coverage, primarily CHAMPUS, declined, as did coverage in the private nongroup market. Nevertheless, the increase in public coverage under Medicaid and SCHIP, combined with the continued increase in private coverage, led to a reduction in the number of uninsured children by 1.7 million between 1998 and 2000 (from 15.6% to 13.3%). Because of the earlier rise in the number of uninsured children, however, these gains netted an overall reduction of only 500,000 uninsured children, using 1994 as the baseline. (For a detailed summary of data on this topic, see Appendix 1 at the end of this article.)

Changing Health Insurance Coverage of Children

Data from the Current Population Survey (CPS), using the verification question introduced in the 2000 CPS (see Box 1), indicates that 9.2 million children in the United States, or about 12% of all children nationwide, were uninsured in 2000.[12] But the child population in the United States was undergoing important structural changes during the 1990s that affected the distribution of coverage. Some groups gained while others lost. Figure 2 summarizes the uninsurance rates across different groups of children by family income, parents' work status, child's age, child's race/ethnicity, parents' citizenship status, and geographic location.[13]

Differences by Family Income

In simple terms, the rate of uninsurance declines as family income rises. Between 1994 and 2000, however, the distribution of uninsured children by income shifted somewhat, with uninsured children becoming increasingly more likely to live in families with higher incomes. More specifically, the share of uninsured who were poor declined by 2.1 percentage points. This decline occurred principally because of decreases in the number of children in poverty.

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Box 1

The Current Population Survey

The Current Population Survey (CPS) is an annual survey of the noninstitutionalized population living in the United States. The survey is sponsored by the Bureau of Labor Statistics and the Census Bureau. The *March CPS Supplement* is the primary source of detailed information on income and work experience in the United States, including information about insurance status during the previous calendar year for all household members.

Trend analysis. The CPS is the only national survey that allows for annual analysis of coverage trends over this period. This article draws on *March CPS Supplement* data from 1995 through 2001 to examine trends in children's insurance coverage, document the uninsured rates among different subgroups of children, and examine changes in the composition of the population of uninsured children.

Verified versus unverified data. Before 2000, survey respondents who did not report having any form of coverage were counted as uninsured. Beginning in 2000, however, an important change was made: Respondents were asked to confirm the lack of insurance for household members by verifying that the lack of any positive indication of a particular form of coverage meant that they lacked health insurance altogether. With such verified data, uninsured rates are uniformly lower than when using unverified data. For example, in 2001, this verification question resulted in a reduction in the percentage of children who were uninsured from 13.3% to 12.0% (10.2 million to 9.2 million).

For more information, see the CPS Web site at: http://www.bls.census.gov/cps/cpsmain.htm. For more information about verified versus unverified data, see Nelson, C., and Mills, R. *The March CPS health insurance verification question and its effect on estimates of the uninsured*. U.S. Census Bureau. 2001. Available online at http://landview.census.gov/hhes/hlthins/verif.html.

Between 1994 and 2000, a large number of children left poverty and moved up the income distribution, and nearly as many children gained access to ESI (see Figure 3). This movement to higher family income levels, where ESI is more prevalent, was the major reason for the growth in ESI. Within income groups, there was little change in the likelihood of children having ESI. Apparently, however, as many more parents became employed and increased their income, their children gained employer-sponsored insurance.

Under 100% of Poverty

Between 1994 and 2000, the rate of ESI increased for this group, but the rate of Medicaid and SCHIP coverage dropped sharply, from 54.0% to 47.5%, or 2.9 million fewer children. (See Appendix 1.) As a result, the overall rate of uninsurance for this income group increased from 24.8% to 27.3%. At the same time, because the total number of children below poverty declined by 3.5 million, the number of uninsured poor children actually declined slightly, by 400,000. (If the number of poor children had stayed the same, Medicaid and SCHIP coverage of children would have declined only by about 1.3 million.)

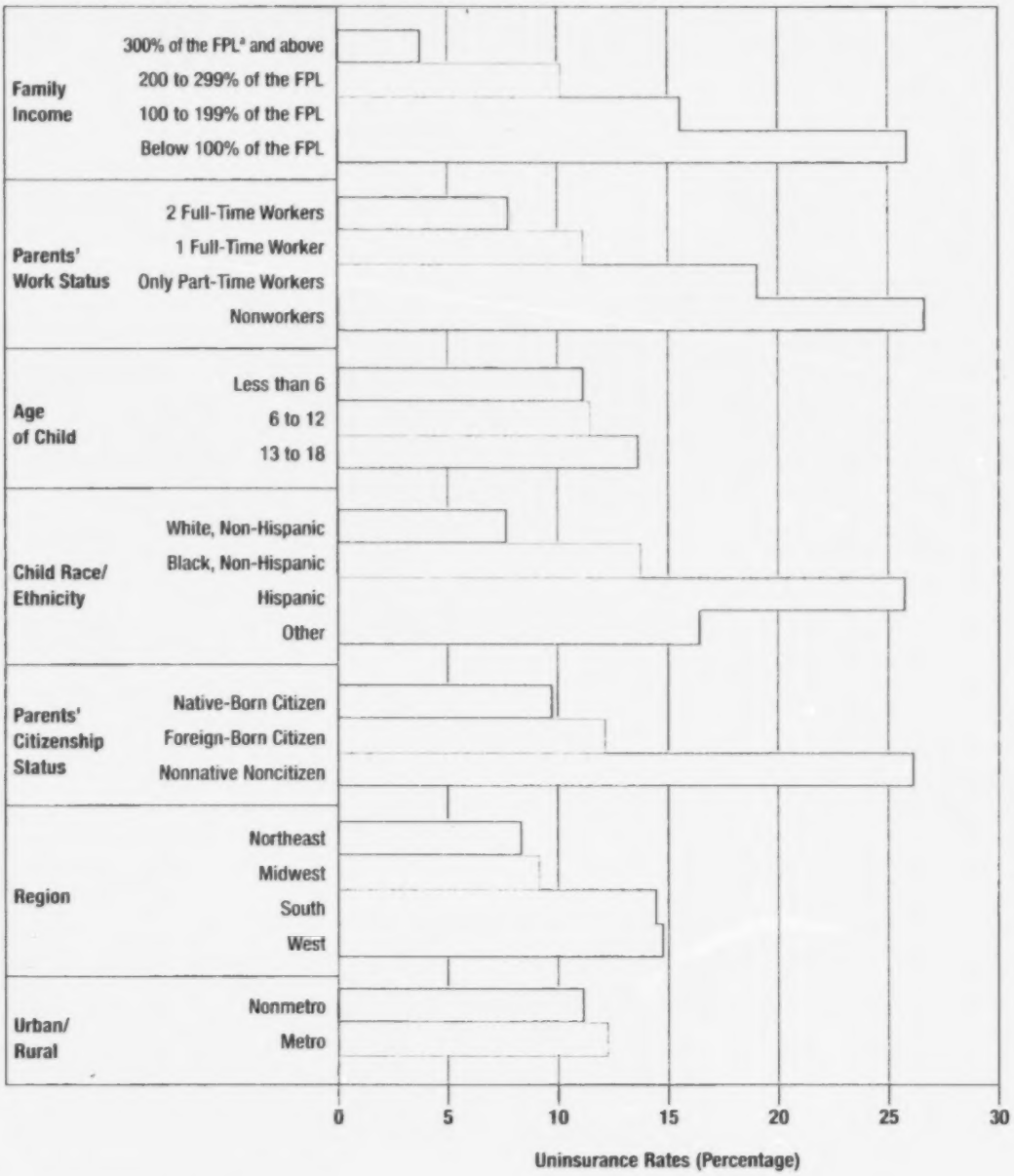
Nevertheless, poor children are dramatically overrepresented among the uninsured: Twenty-seven percent of poor children are uninsured, accounting for nearly one-half of all uninsured children in 2000.[14] These findings are particularly troubling in light of the fact that virtually all these children are eligible for Medicaid or SCHIP.[15]

From 100% to 199% of Poverty

Over this period, the share of uninsured children with family incomes from 100% to 199% of poverty decreased by 4.2 percentage points, probably because of SCHIP and its spillover effects on Medicaid. The rate of Medicaid and SCHIP coverage of this group increased from 16.3% to 23.8% between 1994 and 2000, while the rate of employer coverage remained constant. Because most of this increase occurred between 1998 and 2000, new SCHIP programs appear to have driven the increase in coverage. The growth in Medicaid and SCHIP coverage, along with the stability of employer and other forms of coverage, resulted in a substantial decline in this group's overall uninsurance rate, from 21.7% to 17.5% between 1994 and 2000. Thus, despite a small absolute increase in the size of this income group, the number of uninsured children declined by 600,000.

Figure 2

Uninsurance Rates among Children, by Subgroup (2000)

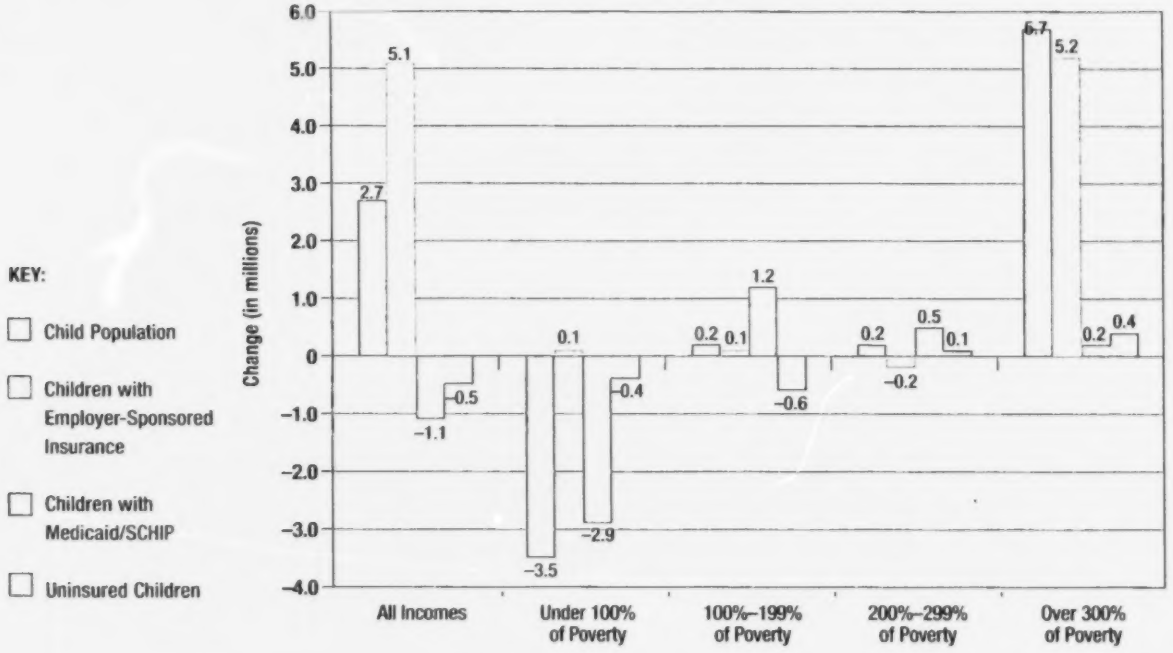


[a] Federal poverty level.

Source: Urban Institute, 2002. Based on verified health insurance coverage data from the March Current Population Survey, 2001. Income was based on the total income of the health insurance unit for the child in relation to census poverty thresholds.

Figure 3

Changes in Child Population and Insurance Coverage by Income Group, 1994 to 2000



Source: Based on data from the 1995 and 2001 Current Population Surveys. Income was based on the total income of the health insurance unit for the child in relation to census poverty thresholds. Similar patterns are observed when income is defined for the legal family. (Changes in CHAMPUS/Medicare and nongroup coverage were small and are not shown.)

From 200% to 299% of Poverty

For children with family incomes between 200% and 299% of poverty, there was no statistically significant change in the uninsurance rate. At the same time, the rate of ESI coverage for this group fell. This seeming paradox is likely due to a compositional change in the families in this income bracket. Families that moved up the income distribution into this bracket were more likely to have ESI coverage for their children than families at lower income levels, but not to the same extent as those already in this income bracket. For example, families may have increased their work hours without gaining fringe benefits. Particularly after 1998, Medicaid and SCHIP coverage almost doubled (3.8% to 6.4%), likely because of SCHIP.

Above 300% of Poverty

Between 1994 and 2000, the share of uninsured children with family incomes above 300% of poverty increased by 4.6 percentage points, reflecting the increase in the population of children in families with incomes above 300% of poverty. As shown in Figure 3, the number of children above 300% of the FPL increased by a huge amount—approximately 5.7 million—with about 5.2 million gaining access to ESI. Although the uninsurance rate of these higher-income children did not increase significantly, the number of uninsured increased by 400,000, simply because of growth in the overall size of this group.

In sum, the declines in uninsurance rates among children were not uniform across different income groups. In par-

ticular, the uninsurance rate for near-poor children declined substantially, especially after the introduction of SCHIP. This decline was principally due to increases in Medicaid and SCHIP coverage rather than increases in the share of children with employer-sponsored coverage. In contrast, uninsurance rates for poor children grew during this time. Furthermore, this increase occurred in the context of a decline in the number of uninsured poor children (by about 400,000); while fewer poor children were uninsured in 2000 than in 1994, a larger percentage of poor children were uninsured, suggesting that children who remained poor in 2000 were more disadvantaged than their 1994 counterparts.

Differences by Age of Child

Overall, younger children had somewhat lower rates of uninsurance in 2000 compared with teenagers (see Figure 2). Changes in coverage between 1994 and 2000, as well as changes in the age distribution of children over this period, help explain the lack of large reductions in uninsurance among children despite economic and public program expansions.

In terms of coverage, the rate of ESI increased for children of all ages, but increased more for younger children than older children (see Figure 4). In contrast, the rate of Medicaid and SCHIP coverage fell more sharply for younger than for older children, probably because Medicaid expansions to older children were phased in over this period and SCHIP increased eligibility more dramatically for older children.[16] Nonetheless, the rate of Medicaid and SCHIP coverage was still much higher for younger children than older children.

Teenagers constitute a somewhat larger share of the uninsured than of all children. (See the article by Brindis, Morreale, and English in this journal issue.) Rates of ESI coverage are higher for older children, but coverage under public programs is significantly lower. SCHIP only recently equalized eligibility for public programs for children of different ages, so these differences may disappear

Children at greatest risk of being uninsured include those in families with incomes below poverty, those in families with nonworkers, those with noncitizen parents, and those who are Hispanic.

as families become more aware of older children's eligibility for public coverage. Meanwhile, as of 1999, participation rates in Medicaid and SCHIP programs among eligible teenagers was about 14 percentage points lower than among eligible children under age six. This large disparity likely accounts, at least in part, for teenagers' higher overall uninsurance rates.[17]

The change in the age distribution of children also helps explain why the growth in ESI and the introduction of SCHIP did not have more of an effect on uninsurance rates. Between 1994 and 2000, the number of children under age 6 fell by 800,000, while the number of children between ages 6 and 18 increased by 3.5 million.[18] Because the rate of Medicaid and SCHIP coverage was higher for younger than for older children, the uninsurance rate for younger children is 1.5 percentage points lower than that of older children. If the population of older U.S. children had not increased as it did, the uninsured rate for children would have been lower. (For a detailed summary of data on this topic, see Appendix 2 at the end of this article.)

Differences by Child Race/Ethnicity

The same patterns of change in coverage occurred within each race/ethnic group between 1994 and 2000: ESI coverage increased, Medicaid and SCHIP coverage declined, and the uninsurance rate declined. However, significant differences in the magnitude of these trends emerged by race/ethnicity. Between 1994 and 2000, the share of uninsured children who were white decreased by 6.5 percentage points, the share who were black stayed roughly the same, whereas the share who were Hispanic increased by 5.5 percentage points (see Figure 5).

White children have much higher rates of ESI overall, primarily because of much higher family incomes. But even within each income group, whites tend to have higher rates of ESI and lower rates of Medicaid and SCHIP coverage. The uninsurance rates for white children within income groups are about the same as for blacks, but substantially lower at each income level than for Hispanics and other race/ethnicity groups.[19]

Hispanic children participate in public programs at similar rates as whites, but have much lower rates of ESI. As a result, Hispanic children have significantly higher rates of uninsurance relative to whites, and these disparities persist at all income levels.[20] In 2000, the uninsurance rates of Hispanic and "other" racial/ethnic groups of children were three times higher than those of whites, and nearly double those of blacks. (See Figure 2.) Moreover, the number of Hispanic children and children in other race/ethnicity groups increased by 2.2 million and 700,000, respectively. Because these children account for all the growth in the total number of children, their higher uninsurance rates are extremely important in understanding trends in coverage among children. In 2000, fully 35% of all uninsured children were Hispanic, even though Hispanic children account for only 16.5% of all children. If this trend persists, the share of uninsured children who are Hispanic will soon outpace the share of white uninsured children, even though Hispanics will still make up a substantially lower percentage of the total child population. (For a detailed summary of data on this topic, see Appendix 3 at the end of this article.)

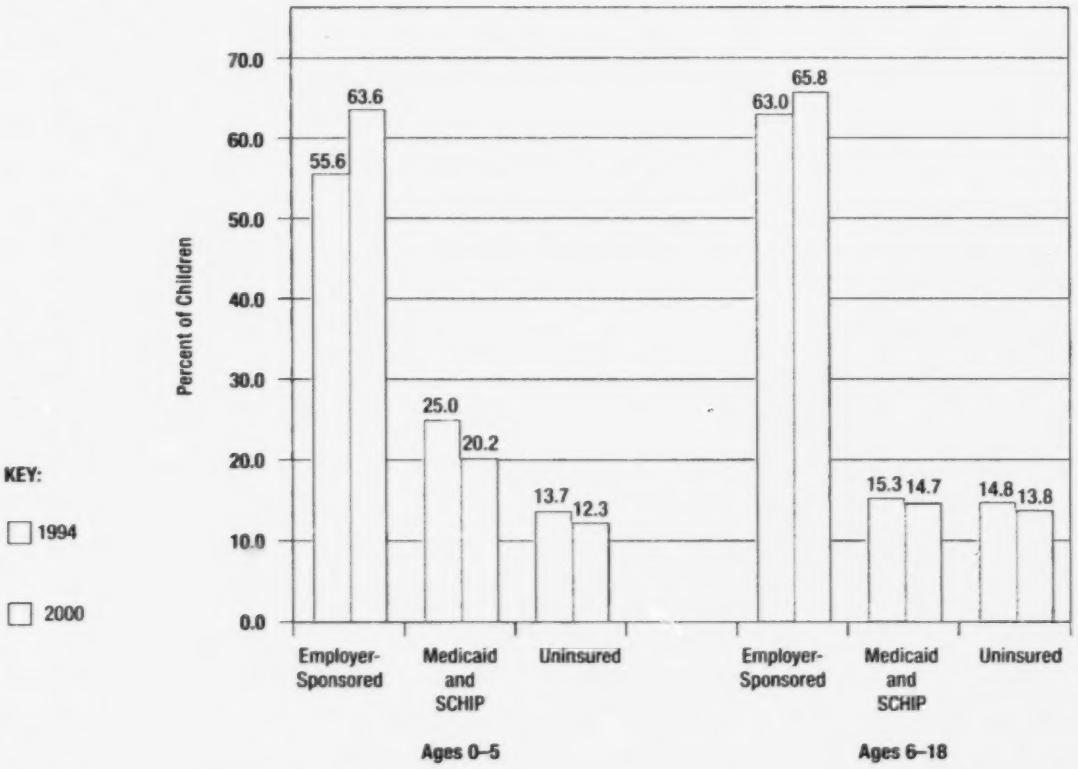
Differences by Parents' Citizenship Status

Uninsurance rates are lowest among children with native-born parents, and somewhat higher for those with foreign-born parents who have obtained citizenship. In contrast, more than one-fourth of children with at least one foreign-born noncitizen parent were uninsured in 2000, and children with at least one foreign-born noncitizen parent were disproportionately represented among the uninsured (constituting 28.4% of uninsured children, compared with only 13.0% of all children). Children of foreign-born parents are consistently more likely to be uninsured than are children of native-born parents throughout the income distribution, with the widest disparities for children with noncitizen parents.

Between 1994 and 2000, the number of uninsured children with native-born parents decreased, while those with foreign-born parents, regardless of citizenship, increased. This trend may be the result of changes in eligibility for public programs stemming from the welfare

Figure 4

Children's Health Insurance Coverage, by Age of Child



Source: Based on data from the 1995 and 2001 Current Population Surveys. (Changes in CHAMPUS/Medicare and in nongroup coverage were small and are not shown.)

reform bill combined with fear of being categorized as a "public charge," which could affect an individual's immigration status. (For a more detailed discussion of immigrant issues, see the article by Lessard and Ku in this journal issue.)

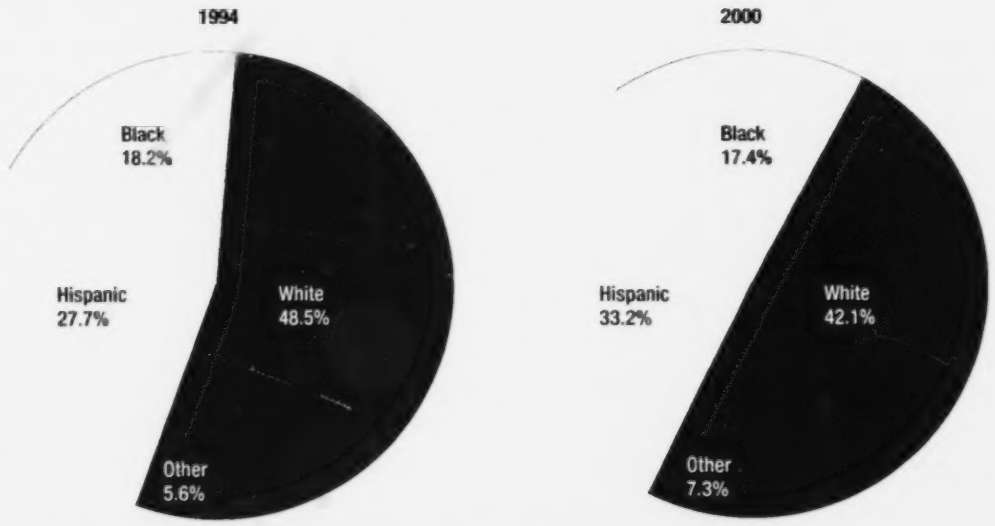
Differences by Geographic Location

Finally, children's uninsurance rates varied dramatically by region. Due to a complex set of circumstances, children in the South and West were about 1.7 times more likely to be uninsured than children in the Northeast. Although eligibility for public programs did not vary importantly across regions, ESI rates and the racial/ethnic and income distribution of the population did vary in ways that are correlated with uninsurance rates. In contrast, urban versus rural residence made no difference in uninsurance rates for children.

In sum, uninsurance rates vary greatly across different subgroups. Children at greatest risk of being uninsured include those in families with incomes below poverty, those in families with nonworkers, those with noncitizen

Figure 5

Composition of Uninsured Children, by Race/Ethnicity



Source: Urban Institute, 2002. Based on unverified health insurance coverage data from the 1995 and 2001 Current Population Surveys.

parents, and those who are Hispanic. Because subgroups vary in size, however, some subgroups of children may have very high rates of uninsurance but represent a small share of the uninsured. Efforts to insure these populations are important, but may not go a long way toward achieving significant reductions in overall uninsurance rates.

To develop effective mechanisms to solve the problem of uninsurance overall, it is critical to understand which subgroups constitute the largest proportion of the uninsured. An assessment of the data from this perspective is summarized in Box 2. These findings reinforce the need to focus on children in poor families, those who are Hispanic, and those with a noncitizen parent. In addition, the findings suggest that children in low-income families with at least one full-time worker may also warrant special attention, as well as children living in certain regions, especially the South and West, and those living in metropolitan areas.

Solving the Problem of Uninsured Children

Public insurance programs such as Medicaid and SCHIP offer tremendous potential for solving the problem of lack of insurance among children. The overwhelming majority of low-income children who are uninsured appear to be eligible for either Medicaid or SCHIP. The key issue is how to reach and enroll them in the programs. Understanding the factors associated with participation or lack of participation in Medicaid and SCHIP, as well as the reasons low-income parents do not enroll their eligible uninsured children, is critical to identifying effective outreach efforts. (See the article by Cohen Ross and Hill.)

The Extent to Which Medicaid and SCHIP Can Reduce Uninsurance

Data from the National Survey of America's Families (NSAF) (see Box 3) indicate that among all uninsured children age 17 and under, more than three-quarters (77%)[21] were eligible for some type of public health insur-

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ance coverage in 1999 (see Figure 6). An even higher percentage of low-income, uninsured children (84%) were eligible for public coverage (see Figure 6). Greater numbers of uninsured children are eligible for Medicaid than SCHIP: Over one-half of all uninsured children are eligible for Medicaid, compared with only about one-quarter for SCHIP. Among low-income, uninsured children, well over one-half (60%) were eligible for Medicaid, compared with 25% for SCHIP.

Overall, about 17% of uninsured children have family incomes that are too high to qualify for Medicaid or SCHIP. Most (about 70%) of these children's families have incomes above 300% of the FPL. Few public programs are likely to expand to these income levels; thus, these uninsured children are likely to remain beyond the reach of public programs in most states.[22] However, nearly 8% of low-income children also have incomes too high to qualify. This is because as of early 2002, about 12 states had SCHIP eligibility thresholds under 200% of the FPL. As a result, eligibility for low-income children in those states has the potential to be increased.[23]

About 6.2% of uninsured children and 8.0% of low-income, uninsured children live in families that meet the income and other requirements for eligibility but do not appear to qualify for Medicaid or SCHIP coverage because the children are undocumented aliens.[24] The

Box 2

Who Are the Uninsured Children?

- **Family Income.** Poor children constituted 45.7% of uninsured children in 2000 and are dramatically overrepresented among the uninsured.[a] Children in families with incomes between 100% and 200% of the FPL constituted another 27.2% of uninsured children. Children in families with incomes above 200% of poverty accounted for about one-quarter of all uninsured children.
- **Parent's Employment.** Consistent with previous research, close to 70% of all uninsured children had parents with at least one full-time worker. Another 9% had parents who worked only part time. The remaining 21% had no working parents.
- **Age.** Children ages 6 to 12 and teenagers each accounted for about 36% of all uninsured children, with those under age 6 making up the remaining 29%. Unlike the other age groups, teenagers constitute a somewhat larger share of the uninsured than of all children.
- **Race/Ethnicity.** Fully 35% of all uninsured children were Hispanic, although Hispanic children account for only 16.5% of all children. Moreover, while white children accounted for 62.7% of all children, they accounted for 39.5% of all uninsured children. Children of other races and black children accounted for 7.5% and 17.6% of all uninsured children, respectively.
- **Parents' Citizenship Status.** Children with at least one foreign-born noncitizen parent were disproportionately represented among the uninsured, constituting 28.4% of uninsured children. Children with native-born parents and foreign-born parents who were naturalized citizens constituted 65.7% and 5.9% of all uninsured children, respectively—the former being underrepresented among the uninsured compared with their representation among all children, the latter accounting for about the same proportions of both.
- **Residential Location.** Close to 40% of all uninsured children lived in the South, and another 30% lived in the West in 2000. Children living in these regions are overrepresented among uninsured children relative to all children. Uninsured children residing in the Northeast and Midwest accounted for 12.6% and 18.1% of all uninsured children, respectively. The share of uninsured children (and all children) living in metropolitan areas was slightly over 80%.

[a]When children are categorized by CPS family income, the share of uninsured children who are poor decreases to 32.2%.

Source: Urban Institute, 2002. Analysis based on data from 2000 reported in the March Current Population Survey, 2001.

Box 3

National Survey of America's Families

The Urban Institute's Assessing the New Federalism project includes the National Survey of America's Families (NSAF), a nationally representative survey of the noninstitutionalized population that oversamples the low-income population in 13 states. Detailed information is collected on up to two children in each household (one under age 6 and one between ages 6 and 17) from the adult (generally a parent) who knows the most about the child's education and health care. The sample of 35,000 children in 1999 contained information on health insurance coverage, family income, and a broad range of other measures.

For this article, NSAF data were analyzed to examine eligibility and participation in Medicaid and SCHIP based on a simulation model that mimics the eligibility-determination process faced by families. First, eligibility units were created from the household survey data based on which individuals in the household would be considered in the eligibility-determination processes for Medicaid and SCHIP. Second, the following state-specific Medicaid and SCHIP eligibility rules in place as of July 2000 were applied to these units regarding eligibility thresholds, family composition, and work status of the parents: how income is counted, including whose income and what types of unearned income are counted; work, earned income, child care, and child support disregards; asset limits; and validating stepparent and grandparent income. Third, children were categorized into two eligibility groups: (1) those eligible for Medicaid and (2) those eligible for SCHIP.

For more information, see the NSAF Web site at: http://www.urban.org/Content/Research/NewFederalism/NSAF/Overview/NSAFOverview.htm. For more on the simulation model used for the analysis of data on eligibility and participation, see Dubay, L., Haley, J., and Kenney, G. *Children's eligibility for Medicaid and SCHIP: A view from 2000.* Assessing the New Federalism Policy Brief No. B-41. Washington, DC: Urban Institute, January 2002.

importance of this subgroup among uninsured children varies substantially across states[25] and regions, with western states having a substantially higher share of uninsured children who are noncitizens—about 20%. Under federal restrictions, states would have to finance state-only health insurance programs to provide health insurance coverage to these noncitizen children. (See the article by Lessard and Ku.)

These statistics underscore that Medicaid and SCHIP programs can provide insurance coverage to a substantial number of currently uninsured children, particularly low-income children. If these programs can reach and enroll eligible children who are uninsured, more than three-quarters of all uninsured children would have coverage.

Factors Affecting Participation in Medicaid and SCHIP

In theory, children's participation in public health insurance programs should depend on the relative costs and perceived benefits of the different insurance options facing parents. The expectation is that children with greater health care needs and less access to low-cost alternative sources of care will participate in Medicaid and SCHIP programs at higher rates than other children. The research to date points to various factors that appear to influence participation rates for different subgroups of eligible children. These factors can be grouped into four broad categories: program characteristics, children's characteristics, connections with welfare, and geographic location.

Program Characteristics

While several studies[26–28] have examined how participation in public programs varies across different subgroups of children, less is known about how participation is affected by the characteristics of the public health insurance programs themselves,[29] or by access to safety net providers.[30,31] Some small-scale studies have found an association between outreach efforts and enrollment in public programs,[32,33] but it is not clear that the findings from these studies can be generalized. In addition, previous studies suggest that premiums for public coverage dampen participation among the uninsured,[34,35] but no empirical work has been done to assess the impact of premiums within the context of SCHIP.

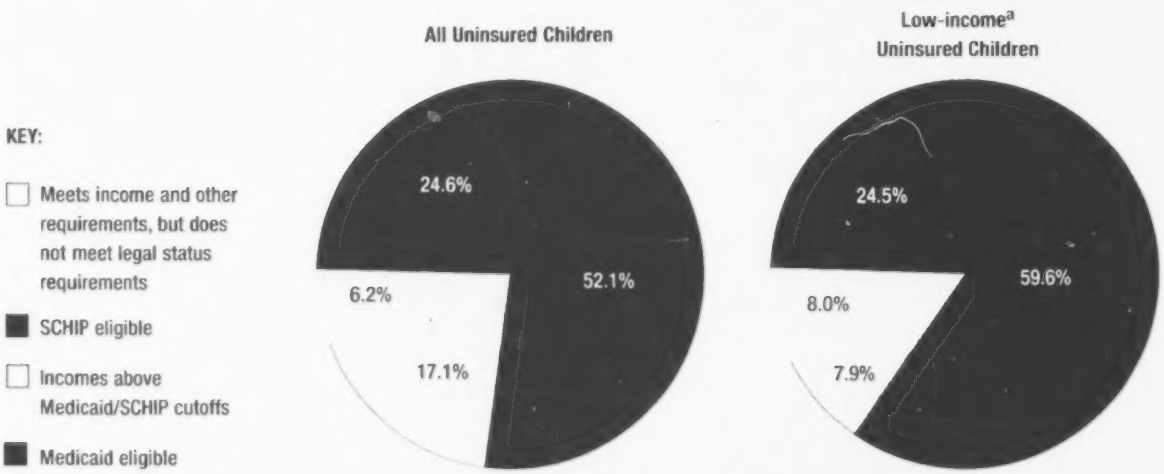
Nevertheless, a growing number of new studies are finding that expanding eligibility for public programs to parents may stimulate greater participation among children who are already eligible but not enrolled.[36–38] Thus, states taking advantage of opportunities to use federal dollars to cover parents[39,40] may increase the enrollment of uninsured eligible children in public health insurance programs by offering coverage to their parents. Moreover, parents' lack of insurance almost certainly exacerbates problems children face in other aspects of their lives. New evidence suggests that whether or not children have coverage, those whose parents lack insurance receive fewer preventive and treatment services than those with insured parents, making these children even more vulnerable.[41] More than 40% of parents in poor families do not have health coverage.[42]

Children's Characteristics

Previous research on how public insurance participation varies with the characteristics of children and families has identified a number of factors, including the child's eligibility category and age, and the parent's birthplace. The most recent NSAF data (1999) found participation rates of 66% among low-income citizen children eligible for Medicaid or SCHIP who did not have private health insurance.[43] Participation rates were highest for children who were eligible under the welfare-related criteria (79%) and lowest for children who were newly eligible for coverage under SCHIP (45%). Children eligible under the poverty-related expansions had a participation rate of 64%.[44] These rates are consistent with historic patterns showing that children eligible under the poverty related expansions participated at lower rates than those eligible under the welfare category.[45–47] The higher participation rates for Medicaid-eligible children relative to those eligible under SCHIP is not surprising, given how short a time most SCHIP expansions had been in place in 1999.[48] Participation rates appear to decline as income rises, but because income and eligibility category are highly correlated, assessing how income affects participation is difficult.

Figure 6

Eligibility for Medicaid or SCHIP among Uninsured Children Ages 0–17, 1999



[a]"Low-income" children are those in families with incomes under 200% of the FPL.

Source: Based on data from the National Survey of America's Families. See Dubay, L., Haley, J.M., and Kenney, G.M. *Children's eligibility for Medicaid and SCHIP: A view from 2000.* Assessing the New Federalism Policy Brief No. B-41. Washington, DC: Urban Institute, March 2002.

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The lower participation rates among older children and those with foreign-born parents may be due in part to larger knowledge gaps found for these groups.

Citizen children who are school-age, children who have activity limitations, and children who have foreign-born parents participate at lower rates than preschool-age children, those with no activity limitations, and those with native-born parents.[49] The lower participation rates among older children and those with foreign-born parents may be due in part to larger knowledge gaps found for these groups.[50,51] For example, greater confusion seems to exist about eligibility rules for older children than for younger children. Low-income, uninsured preschool children are about 15 percentage points more likely than low-income, uninsured school-age children to have parents who think they are eligible for coverage.[52] The higher participation rates for children with functional limitations may reflect greater motivation for parents to enroll their children when they have greater health care needs. In addition, because these children come into contact with the health care system more frequently, their parents are more likely to learn about available Medicaid and SCHIP coverage. (See the article by Szilagyi in this journal issue.)

Connections to Welfare

Participation in Medicaid and SCHIP appears to hinge in part on the family's previous connection to a welfare program and their opinions about welfare.[53] Children whose families had not been enrolled in a welfare program at any point in the two years prior to the survey, for example, were about 15 percentage points less likely to participate in Medicaid or SCHIP compared with children whose families had been on welfare sometime during those two years. The children whose parents had more positive views about welfare—believing that welfare helps people get on their feet, that it does not encourage people to work less or to have babies before marriage—were about 7 to 10 percentage points more likely to participate in Medicaid or SCHIP programs than were children whose parents had less positive views about welfare.

Eligibility for welfare remains closely connected with Medicaid and SCHIP eligibility in many people's minds,[54] even though eligibility for the two types of assistance is no longer linked. In addition, Medicaid and SCHIP participation is lower for children whose parents believe that welfare participation is a prerequisite for Medicaid or SCHIP coverage.[55] Thus, raising participation in Medicaid and SCHIP programs may require building more outreach efforts outside the traditional welfare system and further clarifying the independence of Medicaid and SCHIP eligibility from welfare receipt.

Geographic Location

Participation rates also vary by residential location and across regions and states (see Figure 7). Children living in metropolitan statistical areas (MSAs) are about 10 percentage points more likely than those living outside MSAs to participate in Medicaid and SCHIP.[56] This is consistent with other data that suggest that low-income families with uninsured children living in rural areas are more confused about eligibility rules for Medicaid and SCHIP programs compared to their urban counterparts.[57] With regard to regional variation in participation among citizen children, in 1999 the lowest rates (around 66%) were in Midwestern and Southern states and the highest rates were in the Northeast (79.8%). The average participation rate in the Western states was 72.5%. In addition to regional variation, substantial interstate variation exists. In 1999, for example, citizen children in Massachusetts, New York, and Washington participated in Medicaid at rates of 80% or higher, well above the national average, compared with rates of 64% and 59%, respectively, for Mississippi and Texas, both below the national average.[58]

That some states achieved much higher rates of Medicaid participation than others did calls for greater understanding of the policy or program characteristics that explain their success. For example, in Massachusetts, more than 90% of all eligible children were participating, and only 7% of the state's low-income children remained uninsured.[59,60] The broad-based, seamless approach to covering low-income children, their parents, and other low-income adults that Massachusetts undertook through its MassHealth program may have been partially responsible for this outcome—as well as the state's substantial investment in outreach and its greatly simplified

enrollment process. An important test is whether these high participation rates can be maintained in the face of shortfalls in Massachusetts' tax revenues, and whether they can be replicated by other states attempting similar outreach initiatives and coverage expansions.

Reasons Eligible Children Are Not Enrolled in Medicaid and SCHIP

NSAF data from 1999 identified a variety of reasons low-income, uninsured citizen children who are eligible for public coverage do not participate in Medicaid or SCHIP programs.[61] These included lack of key information about coverage, problems parents experience with the enrollment process, and lack of interest in public health insurance generally.[62] In addition, many uninsured children had been enrolled previously, and may have lost coverage inadvertently through the redetermination process.

Lack of Information

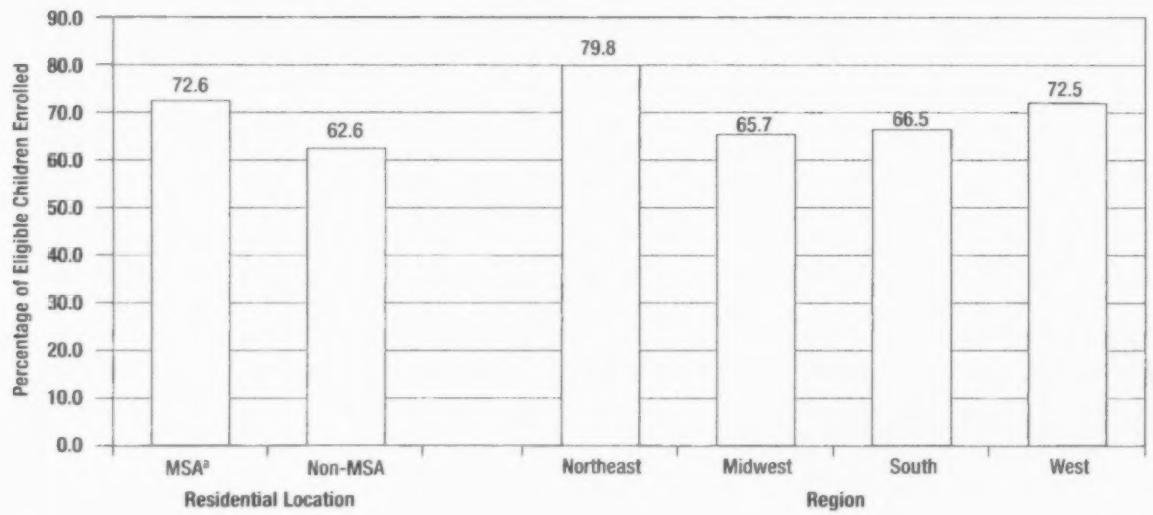
Many low-income families with uninsured children lack basic information about the availability of coverage, especially under newer SCHIP programs, and do not understand that their children are eligible for coverage. Altogether, the parents of 27% of all uninsured eligible children in 1999 reported that they had not heard of Medicaid or SCHIP, had not inquired about or applied for coverage because they thought their child was not eligible, or did not have enough program information to apply. More recent information from early 2001 indicates that such knowledge gaps persist for many low-income parents with uninsured children.[63]

Enrollment-Related Problems

About 1 in 10 low-income, uninsured children who were citizens and eligible for Medicaid or SCHIP coverage in

Figure 7

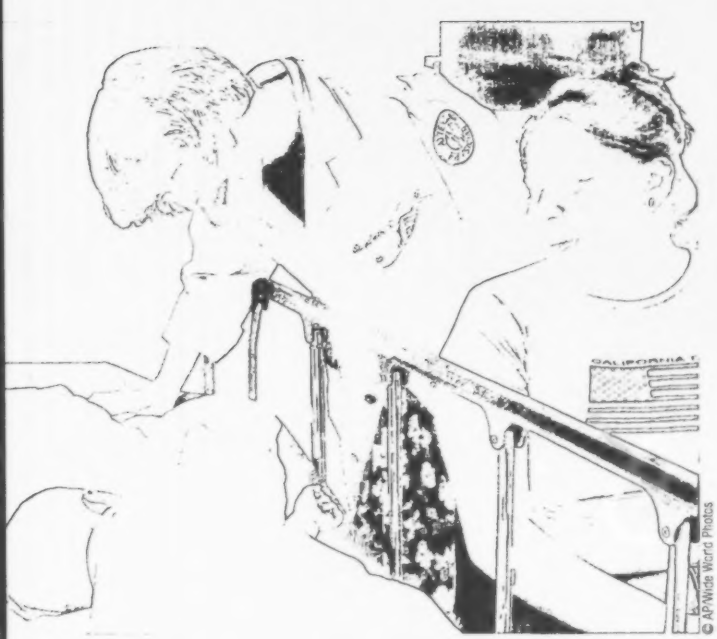
Medicaid/SCHIP Participation Rates by Residential Location and Region, 1999



[a] Metropolitan statistical area.

Note: Excludes children with private coverage.

Source: Urban Institute tabulations of data on low-income children (in families with incomes under 200% of the FPL), ages 0 to 17, from the 1999 National Survey of America's Families.



1999 had parents who said they had not inquired about or applied for coverage because of administrative hassles related to the enrollment process. These included not being able to obtain necessary documents, transportation problems, and language barriers. Evidence from early 2001 confirms the persistence of negative perceptions about the Medicaid and SCHIP application processes.[64] Families may not realize that the Medicaid and SCHIP enrollment processes have been simplified—including the introduction of mail-in applications in many states. (See the article by Cohen Ross and Hill.)

In addition, applications for Medicaid and SCHIP coverage had been made on behalf of 11.5% of all currently uninsured citizen children who appeared to qualify for such coverage. Understanding why these uninsured children are still not enrolled in Medicaid or SCHIP is necessary to develop effective approaches for covering these children—they may be awaiting an eligibility determination and will not remain uninsured.

Not Needing or Wanting Coverage

In 1999, the parents of about 23% of all eligible uninsured citizen children said they did not inquire about or apply for Medicaid and SCHIP coverage on behalf of their child either because they did not want public health insurance coverage or they felt it was not needed. These uninsured children tend to be in better health and to have fewer unmet needs relative to other uninsured children, which may partially explain why their parents felt they did not need or want Medicaid and SCHIP coverage.[65] These families also may have negative views about Medicaid and SCHIP because they link those programs with welfare or because they have a safety net provider they know and trust.

Problems Maintaining Coverage

Another subgroup of uninsured citizen children includes those who were previously enrolled in Medicaid or SCHIP but lost their coverage. Fully 22.4% of low-income children who were uninsured at the time of the NSAF survey had been enrolled in Medicaid or SCHIP at some point in the 12 previous months. These children may have lost coverage inadvertently through the eligibility-redetermination process.

In sum, children with greater health care needs, younger children, and children whose parents have positive attitudes toward welfare are most likely to participate in public health insurance programs. In addition, recent evidence suggests that participation is higher when the whole family is eligible for coverage.[66] While lack of knowledge and understanding about eligibility for Medicaid and SCHIP is an important issue for some families with uninsured children, other influential factors include administrative complexities and perceptions that parents do not need or want insurance. Overall, the reasons parents have not enrolled their uninsured eligible children are complex and varied, suggesting that a range of outreach and enrollment strategies is needed if participation is going to be increased.

Conclusions and Policy Implications

Despite the strong economy and the unparalleled commitment to covering children under the Medicaid and SCHIP programs, more than 9 million children—12% of all children—lacked health insurance coverage in 2000. Importantly, the vast majority of these children are eligible for Medicaid or SCHIP.

Between 1994 and 2000, the uninsurance rate for children fell from 14.5% to 13.3%, representing a decrease of 500,000 in the number of uninsured children. Yet, these gains were not solely or even mainly attributable to the expansions in eligibility for public programs that took place over this period. In fact, welfare reform and the

movement of families up the income distribution resulted in a decline in the share of children with public coverage from 18.5% to 16.4%.

Instead, increases in ESI were much more important than expansions in public programs in explaining the drop in uninsurance rates. The rate of ESI increased from 60.5% to 65.1%, an increase in coverage of 5.1 million children. Had it not been for the buoyant economy moving so many families with children up the income distribution—where the likelihood of ESI is greater and uninsurance rates lower—more children would have been uninsured. This implies that children's coverage could easily decline in a weaker economy. Moreover, these trends mask tremendous variation in coverage for different groups of children.

Many reasons account for children's continued lack of enrollment in health insurance programs. In some states, SCHIP eligibility standards are below 200% of poverty, leaving some near-poor children without access to affordable health insurance. In other states, many uninsured children are noncitizens who are not eligible for Medicaid or SCHIP under current federal law.

In most states, however, the problem is not inadequate eligibility levels, but lack of participation among uninsured children who are eligible. The factors responsible for low participation among those eligible for public insurance include poor outreach and cumbersome enrollment processes. In other cases, the issue may lie with families. Some parents believe that their children do not need insurance, possibly because they assume care will be available when needed from safety net providers. A few may not wish to join public programs, particularly Medicaid, because of the stigma attached to welfare-related programs.

These results present a mixed picture of the potential of public health insurance programs to solve the problem of uninsurance among children. On the one hand, the declines in uninsurance experienced by low-income children, and the steeper declines among the near-poor, particularly after SCHIP was implemented, are an encouraging sign that these public efforts are producing results. It is especially likely that SCHIP is largely responsible for the decline in uninsurance among low-income children, since parents (who are much less likely than their children to have access to Medicaid or SCHIP) did not experience a comparable decline.[67]

On the other hand, many poor children—4.4 million in all—still lack health insurance coverage. This group has a 27% uninsurance rate despite the fact that virtually all poor children, except certain groups of noncitizens, qualify for public coverage. One explanation may be a reduced understanding of eligibility since the advent of welfare reform. Moreover, given recent declines in the welfare rolls, fewer needy families may be coming into contact with the types of government programs that historically have facilitated their enrollment in public health coverage programs.[68]

Under the current structure, lack of participation among eligible uninsured children may not change. Furthermore, modest changes to the structure will affect coverage only marginally—because states will always vary in their willingness to expand coverage and finance outreach efforts, and some families will always choose, for whatever reason, not to insure their children, no matter how attractive the program. The weakening economy and rising health care costs make it less likely that states and employers will maintain their current level of support, let alone increase it.

To increase participation among uninsured children, a number of major changes to current policy are needed. Though certain to be politically difficult, these changes are necessary to address current problems.

- *Increase the federal Medicaid matching rate to SCHIP levels.* This would address problems that have reportedly arisen in some states—in particular, concern that outreach for SCHIP will lead to more enrollment of children in Medicaid (rather than SCHIP), which has a lower federal matching rate. This change would help make states financially indifferent in dealing with Medicaid and SCHIP and could help reduce the very high uninsurance rates that have persisted among poor children. The increase in federal dollars (about $5 billion) will also offset most of the higher costs to states associated with the other recommendations.

- *Mandate that to obtain SCHIP funding, states must provide coverage under SCHIP to at least 200% of the FPL.* This should be relatively easy, because only 12

states currently provide coverage only to children whose families are below 200% of the FPL, but this action would set an important precedent of a uniform minimum standard for the coverage of children.

- *Require that federal and state governments minimize many differences between Medicaid and SCHIP.* While Medicaid serves a lower-income population and its benefit package arguably should be broader, the federal government should work with states to achieve uniformity in outreach and enrollment efforts, provider payment rates, and managed care contracting provisions. The goal should be to ensure that the two programs are equally attractive, though with some benefit reductions, and insurance premiums, and cost sharing for higher-income children.

- *Fund a major federal campaign to (1) educate families on the value of health insurance and health care services for children, (2) provide information on the benefits of enrolling in Medicaid and SCHIP, and (3) provide information on how to enroll in either program in each community and state.* This needs to be a federal campaign because expanding insurance coverage of children is a national, not just a state, objective. Federally funded grants to local organizations may also be required to help families successfully navigate the Medicaid and SCHIP enrollment processes.

To the extent that even these efforts leave many low-income children uninsured, solving the problem could require mandating that all families with children who are eligible for Medicaid or SCHIP insure their children—and accompanying the mandate with subsidies that families can use to enroll children in an employer's plan, an individual policy, Medicaid, or SCHIP. This type of program would provide more equal treatment of those with equal incomes, regardless of coverage, than does the current system (referred to as "horizontal equity"; see the article by Blumberg in this journal issue). Such a program would likely require much greater increases in public funding than the other policy changes outlined above, but this level of investment ultimately may be required to achieve the goal of health insurance coverage for all American children.

ENDNOTES

1. This compares with 17.6% of nonelderly adults who were uninsured in 2000. See Holahan, J., and Pohl, M. Changes in insurance coverage: 1994–2000 and beyond. Health Affairs Web Exclusive, April 3, 2002. Available online at http://www.healthaffairs.org/WebExclusives/Holahan_Web_Excl_040302.htm.

2. Newacheck, P.W. The role of Medicaid ensuring children's access to care. *Journal of the American Medical Association* (1998) 280 (20):1789–93.

3. Rosenbach, M.L. The impact of Medicaid on physician use by low-income children. *American Journal of Public Health* (1989) 79(9):1120–26.

4. Davidoff, A.J., and Garrett, A.B. Determinants of public and private insurance enrollment among Medicaid-eligible children. *Medical Care* (2001) 39(6):523–35; Dubay, L., and Kenney, G.M. Health care access and use among low-income children: Who fares best? *Health Affairs* (January/February 2001) 20(1):112–21; Racine, A., Kaestner, R., Joyce, T.J., and Coleman, G.J. Differential impact of recent Medicaid expansions by race and ethnicity. *Pediatrics* (2001) 108(5):1135–42; and Institute of Medicine. *Coverage matters: Insurance and health care*. Washington, DC: National Academy Press, 2001.

5. Estimates of the extent to which uninsured children are eligible for Medicaid or SCHIP coverage depend on assumptions regarding the accuracy of insurance coverage information reported on household surveys. The range (65% to 75%) reflects two different estimation strategies—the lower end of the range is based on unpublished Urban Institute estimates for the CPS that attempted to adjust for the underreporting of Medicaid and SCHIP coverage, while the upper end of the range is based on estimates for the NSAF that did not attempt to adjust for potential underreporting of Medicaid and SCHIP coverage. To the extent that Medicaid and SCHIP coverage is underreported on the survey data, uninsurance rate estimates are likely to be overstated and participation rate estimates are likely to be understated. All the estimates presented in the remainder of this article do not attempt to adjust for possible underreporting of public coverage.

6. In this article, children are defined as those who are either age 18 and under or age 17 and under, depending on the analysis. Children age 18 and under constitute 27.7% of the total population in the United States.

7. Newacheck, P., Hughes, D., and Cisternas, M. Children and health insurance: An overview of recent trends. *Health Affairs* (1995) 14(1):244–54.

8. Weinick, R.M., Weigers, M.E., and Cohen, J.W. Children's health insurance, access to care, and health status: New findings. *Health Affairs* (1998) 17(2):127–36.

9. Almeida, R., and Kenney, G.M. *Gaps in insurance coverage for children: A pre-CHIP baseline*. Assessing the New Federalism Policy Brief No. B-19. Washington, DC: Urban Institute, May 2000.

10. However, the *number* of uninsured children fell by only 500,000, because of population growth.

11. Garrett, B., and Holahan, J. Health insurance coverage after welfare. *Health Affairs* (January/February 2000) 19(1):175–84; and Families USA. *Go directly to work, do not collect health insurance: Low income parents love Medicaid*. Washington, DC: Families USA, June 2000.

12. Because verified data were not available before 2000, unverified data on health insurance coverage from the March 1995 and March 2001 CPS were used to analyze trends.

13. For detailed tables summarizing these data, see Appendices 1, 2, and 3 at the end of this article.

14. When children are categorized by CPS family income, the share of uninsured children who are poor decreases to 32.2%.

15. The only poor children not eligible for one of these programs in 2000 were either illegal aliens or "qualified aliens" who entered the country after 1996 and resided in states that do not cover such children.

16. Ullman, F., Hill, I., and Almeida, R.A. *CHIP: A look at emerging state programs*. Assessing the New Federalism Policy Brief No. A-35. Washington, DC: Urban Institute, 1999.

17. See note 16, Ullman, et al.

18. National Center for Health Statistics. *National vital statistics reports*. Vol. 49, no. 1. Hyattsville, MD: NCHS, April 17, 2001.

19. Black children also have lower rates of ESI than white children have, but they participate in public programs at much higher rates. Thus, the overall rate of uninsurance among black children is more comparable to white children than to Hispanic children.

20. Dubay, L., Kenney, G.M., and Haley, J. *Children's participation in Medicaid and SCHIP: Early in the SCHIP era*. Assessing the New Federalism Policy Brief No. B-40. Washington, DC: Urban Institute, January 2002.

21. Recent estimates using the CPS attempted to take into account both growth in enrollment through December 2002 and underreporting of public coverage. Thus, these estimates imply both greater participation in Medicaid and SCHIP, and lower eligibility for Medicaid and SCHIP among children who remain uninsured. According to these estimates, 65% of all uninsured children are eligible for either Medicaid or SCHIP. As participation increases in these programs, the share of uninsured children who are not eligible for either program should decline. See note 1, Holahan and Pohl.

22. Several states, including Missouri, New Jersey, and Vermont have expanded coverage to 300% of the FPL or even higher.

23. Kaiser Commission on Medicaid and the Uninsured. *State income eligibility guidelines for children's regular Medicaid, children's SCHIP-funded Medicaid expansions and SCHIP-funded separate child health insurance programs*. Menlo Park, CA: The Henry J. Kaiser Family Foundation, January 2002.

24. See Dubay, L., Haley, J., and Kenney, G.M. *Children's eligibility for Medicaid and SCHIP: A view from 2000*. Assessing the New Federalism Policy Brief No. B-41. Washington, DC: Urban Institute, January 2002. The NSAF does not collect sufficient information to determine whether foreign-born children who are not citizens are eligible for Medicaid and SCHIP. About 40% of all noncitizen children and slightly over one-half of uninsured noncitizen children were undocumented, according to estimates based on the March 2000 CPS and Urban Institute imputations of legal status of immigrants. (See Passel, J.S., and Clark, R.L. *Immigrants in New York: Their legal status, incomes, and taxes*. Washington, DC: Urban Institute, 1998, for a discussion of the methodology used to impute legal status to foreign-born noncitizens using the CPS.) The esti-

mates here were adjusted to reflect the legal status of noncitizens based on CPS estimates of the share of foreign-born, undocumented, noncitizen children.

25. Capps, R. *Hardship among children of immigrants: Findings from the 1999 National Survey of America's Families (NSAF).* Assessing the New Federalism Policy Brief No. B-29. Washington, DC: Urban Institute, February 2001.

26. Selden, T.M., Banthin, J.S., and Cohen, J.W. Waiting in the wings: Eligibility and enrollment in the State Children's Health Insurance Program. *Health Affairs* (1999) 8(2):126–33.

27. Selden, T.M., Banthin, J.S., and Cohen, J.W. Medicaid's problem children: Eligible but not enrolled. *Health Affairs* (1998) 17(3):192–200.

28. See note 4, Davidoff and Garrett; and note 20, Dubay, et al. See also Dubay, L., and Kenney, G.M. Revisiting the issues: The effects of Medicaid Expansions on insurance coverage of children. *The Future of Children* (1996) 6(1):152–61.

29. The Barrents Group. Review of the literature of outreach for public health insurance and selected other programs. Rockville, MD: The Agency for Healthcare Research and Quality, March 2000.

30. See note 4, Davidoff and Garrett.

31. Rask, K.N., and Rask, K.J. Public insurance substituting for private insurance: New evidence regarding public hospitals, uncompensated care funds, and Medicaid. *Journal of Health Economics* (2000) 19:1–31.

32. Stine, W.F. The effect of local government outreach efforts on the recipients of selected Medicaid programs. *Inquiry* (Summer 1991) 28:161–68.

33. Mayer, J. A time series study of the impact of eligibility expansion on Medicaid financing of births. *Journal of Health & Social Policy,* (1992) 4(2):1–17.

34. Ku, L., and Coughlin, T.A. Sliding-scale premium heath insurance programs: Four states' experiences. *Inquiry* (Winter 1999/2000) 36:471–80.

35. Marquis, M.S., and Long, S.H. Worker demand for health insurance in the non-group market. *Journal of Health Economics* (1995) 14(1):47–64.

36. Dubay, L., and Kenney, G.M. *Expanding public health insurance to parents: Effects on children's coverage under Medicaid. Health Services Research.* Forthcoming.

37. Lambrew, J. *Health insurance: A family affair: A national profile and state-by-state analysis of uninsured parents and their children.* New York: The Commonwealth Fund, 2001.

38. Ku, L., and Broaddus, M. *The importance of family-based insurance expansions: New research findings about state health reforms.* Washington, DC: Center on Budget and Policy Priorities, 2000.

39. Dubay, L., Kenney, G.M., and Zuckerman, S. *Extending Medicaid to parents: An incremental strategy for reducing the number of uninsured.* Assessing the New Federalism Policy Brief Series No. B-20. Washington, DC: Urban Institute, June 2000.

40. Guyer, J., and Mann, C. *Taking the next step: States can now take advantage of federal Medicaid matching funds to expand health care coverage to low-income working parents.* Washington, DC: Center on Budget and Policy Priorities, August 1998.

41. Davidoff, A.J., Kenney, G.M., Dubay, L., and Yemane, A. The effect of parent's insurance coverage on access to care for children. Draft.

42. Dubay, L., and Kenney, G.M. How much can Medicaid and SCHIP expansions address coverage gaps for parents? Draft.

43. The analyses of Medicaid or SCHIP participation, and of the reasons eligible but uninsured children are not enrolled, focus on children who are citizens (either U.S.-born or naturalized). Noncitizen children are excluded because their Medicaid and SCHIP eligibility could not be accurately determined. The participation rates reported here exclude children with private coverage, in order to assess the extent to which Medicaid and SCHIP programs are reaching the target population of uninsured children in 2000. In addition, children with Medicare coverage only also are excluded; because they represent a very small share of low-income children, their exclusion has almost no effect on the estimates presented in this article. At the same time, as in all household surveys, it is possible that public insurance coverage is underreported in NSAF. Thus, the participation rates reported here may underestimate actual participation rates if some respondents did not report their children's participation. Because the names of state Medicaid and SCHIP programs are not always distinguished, enrollment in either Medicaid or SCHIP was determined on the basis of the simulation model (see Box 3). See note 20, Dubay, et al.

44. In the late 1980s, the federal government mandated a series of Medicaid expansions to low-income children. All citizen children living below the FPL and children age six and under living below 133% of the FPL were made eligible for Medicaid.

45. Selden, T.M., Banthin, J.S., and Cohen, J.W. Waiting in the wings: Eligibility and enrollment in the State Children's Health Insurance Program. *Health Affairs* (1999) 8(2):126–33.

46. See note 4, Davidoff and Garrett.

47. Dubay, L., and Kenney, G.M. Revisiting the issues: The effects of Medicaid Expansions on insurance coverage of children. *The Future of Children* (1996) 6(1):152–61.

48. In 1999, low-income families were about twice as likely to have heard of Medicaid programs as to have heard of the separate SCHIP programs. See Kenney, G.M., Haley, J., and Dubay, L. How familiar are low-income parents with Medicaid and SCHIP? Washington, DC: Urban Institute. Assessing the New Federalism Policy Brief B-34 (2001).

49. See note 20, Dubay, et al.

50. Feinberg, E., Swartz, K., Zaslavsky, A.M., et al. Language proficiency and the enrollment of Medicaid-eligible children in publicly funded health insurance programs. *Maternal and Child Health Journal* (2002) 6(1):5–18.

51. Kenney, G.M., Haley, J., and Blumberg, S. Awareness and perceptions of Medicaid and SCHIP programs among low-income families with uninsured children. Findings from early 2001. Washington, DC: Report submitted to the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2002.

52. See note 51, Kenney, et al.

53. See note 49, Dubay and Kenney.

54. See note 48, Kenney, et al.

55. See note 20, Dubay, et al.

56. Metropolitan Statistical Area: The general concept of a metropolitan area (MA) is one of a large population nucleus, together with adjacent communities that have a high degree of economic and social integration with that nucleus. Each MA must contain either a place with a minimum population of 50,000 or a Census Bureau-defined urbanized area and a total MA population of at least 100,000. An MA comprises one or more counties. An MA may also include one or more outlying counties that have close economic and social rela-

tionships with the central county. An outlying county must have a specified level of commuting to the central counties and also must meet certain standards regarding metropolitan character, such as population density, urban population, and population growth.

Primary Metropolitan Statistical Area: If an area that qualifies as an MA has more than 1 million persons, primary metropolitan statistical areas (PMSAs) may be defined within it. PMSAs consist of a large urbanized county or cluster of counties that demonstrate very strong internal economic and social links, in addition to close ties to other portions of the larger area. When PMSAs are established, the larger area of which they are component parts is designated a consolidated metropolitan statistical area (CMSA). Metropolitan Statistical Area: Metropolitan statistical areas (MSAs) are relatively freestanding MAs and are not closely associated with other MAs. These areas typically are surrounded by nonmetropolitan counties.

57. See note 51, Kenney, et al.

58. See note 51, Kenney, et al.

59. See note 20, Dubay, et al.

60. Zuckerman, S., Kenney, G.M., Dubay, L., et al. Shifting health insurance coverage, 1997–1999. *Health Affairs* (Jan./Feb. 2001) 20(1):169–77.

61. To analyze why uninsured citizen children who appeared to be eligible for Medicaid or SCHIP were not participating, this study combined information collected about (a) awareness of their state SCHIP; (b) awareness of the Medicaid program; (c) whether the child had participated in Medicaid or SCHIP at some point in the past year; (d) whether parents who had heard of Medicaid or SCHIP had inquired about coverage on behalf of the child in the past year, and if no inquiry had been made, why not; and (e) whether those who had inquired had also applied for coverage on behalf of their child in the past year, and if no application had been made, why not. The information on awareness of and participation in public programs was combined with the main reasons the parent gave for not inquiring about or applying for Medicaid or SCHIP coverage into the following categories: (a) knowledge gaps (parents who had not heard of either program, did not inquire or apply because they did not think their child was eligible, or did not inquire or apply because they did not know enough about the program); (b) administrative hassles; (c) enrolled in past year, but not at present; (d) applied for coverage, but not enrolled; (e) not needing or wanting program; and (f) other reason. Kenney, G.M., and Haley, J. ***Why aren't more uninsured children enrolled in Medicaid or SCHIP?*** Assessing the New Federalism Policy Brief No. B-35. Washington, DC: Urban Institute, May 2001.

62. See note 61, Kenney and Haley.

63. See note 51, Kenney, et al.

64. See note 51, Kenney, et al.

65. See note 61, Kenney and Haley.

66. See note 36, Dubay and Kenney; note 37, Lambrew; and note 38, Ku and Broaddus.

67. See note 42, Dubay and Kenney.

68. Haley, J., and Kenney, G.M. Coverage gaps for Medicaid-eligible children in the wake of federal welfare reform. Urban Institute Working Paper. Washington, DC: Urban Institute, 2002.

Appendix 1

Children's Health Insurance Coverage, 1994–1998, 1998–2000

	1994–1998			1998–2000			
	Coverage Distribution within Income Category		Change in Millions of People	Coverage Distribution within Income Category		Change in Millions of People	Change in Millions of People
	1994	1998	1994–98	1998	2000	1998–00	1994–00
All Incomes (millions of people)	**73.9**	**76.0**	**2.08**	**76.0**	**76.6**	**0.61**	**2.7**
Employer	60.5%	63.2%[a]	3.30	63.2%	65.1%[a]	1.84	5.1[a]
Medicaid and SCHIP	18.5%	15.7%[a]	–1.74	15.7%	16.4%[a]	0.64	–1.1[a]
CHAMPUS/Medicare	2.0%	1.5%[a]	–0.35	1.5%	1.4%	–0.02	–0.4[a]
Private Nongroup	4.5%	4.0%[a]	–0.31	4.0%	3.7%[b]	–0.18	–0.5[a]
Uninsured	14.5%	15.6%[a]	1.17	15.6%	13.3%[a]	–1.66	–0.5[a]
Less than 100% of FPL (millions of people)	**19.7**	**18.0**	**–1.67**	**18.0**	**16.3**	**–1.79**	**–3.5**
Employer	16.5%	19.5%[a]	0.27	19.5%	20.8%	–0.15	0.1[a]
Medicaid and SCHIP	54.0%	46.6%[a]	–2.24	46.6%	47.5%	–0.69	–2.9[a]
CHAMPUS/Medicare	1.2%	0.9%	–0.07	0.9%	1.4%	0.05	0.0
Private Nongroup	3.5%	3.0%	–0.15	3.0%	3.0%	–0.05	–0.2
Uninsured	24.8%	29.9%[a]	0.51	29.9%	27.3%[b]	–0.95	–0.4[b]
100 to 199% of FPL (millions of people)	**14.9**	**14.9**	**0.01**	**14.9**	**15.2**	**0.23**	**0.2**
Employer	53.5%	52.7%	–0.11	52.7%	53.1%	0.18	0.1
Medicaid and SCHIP	16.3%	18.5%[a]	0.33	18.5%	23.8%[a]	0.84	1.2[a]
CHAMPUS/Medicare	3.3%	2.0%[a]	–0.19	2.0%	2.0%	0.01	–0.2[a]
Private Nongroup	5.3%	4.3%[b]	–0.14	4.3%	3.5%	–0.11	–0.2[a]
Uninsured	21.7%	22.4%	0.11	22.4%	17.5%[a]	–0.69	–0.6[a]
200 to 299% of FPL (millions of people)	**13.0**	**13.0**	**0.02**	**13.0**	**13.2**	**0.16**	**0.2**
Employer	77.9%	78.5%	0.10	78.5%	75.2%[a]	–0.31	–0.2[a]
Medicaid and SCHIP	3.1%	3.8%	0.09	3.8%	6.4%[a]	0.35	0.5[a]
CHAMPUS/Medicare	2.5%	2.0%	–0.07	2.0%	1.9%	–0.01	–0.1
Private Nongroup	5.3%	4.4%	–0.12	4.4%	4.7%	0.04	–0.1
Uninsured	11.1%	11.2%	0.02	11.2%	11.8%	0.09	0.1
300%+ of FPL (millions of people)	**26.3**	**30.0**	**3.72**	**30.0**	**32.0**	**2.01**	**5.7**
Employer	89.0%	88.1%	3.04	88.1%	89.2%[b]	2.12	5.2
Medicaid and SCHIP	0.8%	0.9%	0.08	0.9%	1.3%[a]	0.14	0.2[a]
CHAMPUS/Medicare	1.5%	1.3%	–0.02	1.3%	1.0%	–0.07	–0.1[a]
Private Nongroup	4.4%	4.2%	0.10	4.2%	3.7%	–0.07	0.0[b]
Uninsured	4.3%	5.5%[a]	0.52	5.5%	4.9%[b]	–0.11	0.4

Note: Excludes persons age 65 and older and those in the Armed Forces.
[a] Indicates change in percentages is statistically significant (at the 5% level).
[b] Indicates change in percentages is statistically significant (at the 10% level).

Source: Urban Institute, 2001. Based on data from March Current Population Surveys, 1995, 1999, 2001.

Appendix 2

Children's Health Insurance Coverage by Age, 1994–2000

	Children Ages 0–5			Children Ages 6–18		
	Coverage Distribution within Income Category		Change in Millions of People	Coverage Distribution within Income Category		Change in Millions of People
	1994	2000	1994–00	1998	2000	1994–00
All Incomes (millions of people)	**24.4**	**23.7**	**–0.8**	**49.5**	**52.9**	**3.5**
Employer	55.6%	63.6%[a]	1.5	63.0%	65.8%[a]	3.7
Medicaid and SCHIP	25.0%	20.2%[a]	–1.3	15.3%	14.7%[b]	0.2
CHAMPUS/Medicare	2.2%	1.7%[a]	–0.1	1.9%	1.3%[a]	–0.2
Private Nongroup	3.5%	2.1%[a]	–0.4	5.0%	4.4%[a]	–0.1
Uninsured	13.7%	12.3%[a]	–0.4	14.8%	13.8%[a]	–0.1
Less than 100% of FPL (millions of people)	**7.7**	**5.5**	**–2.3**	**12.0**	**10.8**	**–1.2**
Employer	14.3%	18.9%[a]	–0.1	17.9%	21.7%[a]	0.2
Medicaid and SCHIP	61.7%	53.7%[a]	–1.8	49.0%	44.3%[a]	–1.1
CHAMPUS/Medicare	1.5%	1.3%	0.0	1.0%	1.4%	0.0
Private Nongroup	2.0%	1.0%	–0.1	4.5%	4.1%	–0.1
Uninsured	20.4%	25.0%[a]	–0.2	27.6%	28.5%	–0.2
100 to 199% of FPL (millions of people)	**5.0**	**5.0**	**0.0**	**9.9**	**10.1**	**0.2**
Employer	52.3%	52.6%	0.0	54.1%	53.4%	0.1
Medicaid and SCHIP	21.5%	27.5%[a]	0.3	13.7%	21.9%[a]	0.9
CHAMPUS/Medicare	3.7%	2.8%	0.0	3.1%	1.6%[a]	–0.1
Private Nongroup	3.4%	2.4%	–0.1	6.2%	4.1%[a]	–0.2
Uninsured	19.1%	14.8%[a]	–0.2	23.0%	18.9%[a]	–0.4
200 to 299% of FPL (millions of people)	**4.2**	**4.2**	**0.1**	**8.9**	**9.0**	**0.1**
Employer	77.4%	75.9%	–0.1	78.2%	74.9%[a]	–0.2
Medicaid and SCHIP	4.2%	7.9%[a]	0.2	2.6%	5.7%[a]	0.3
CHAMPUS/Medicare	2.8%	2.2%	0.0	2.4%	1.7%	–0.1
Private Nongroup	4.4%	3.2%	–0.1	5.7%	5.4%	0.0
Uninsured	11.2%	10.8%	0.0	11.1%	12.2%	0.1
300%+ of FPL (millions of people)	**7.5**	**9.0**	**1.4**	**18.7**	**23.0**	**4.3**
Employer	88.1%	91.3%[a]	1.5	89.4%	88.3%	3.6
Medicaid and SCHIP	1.1%	1.4%	0.0	0.7%	1.3%[a]	0.2
CHAMPUS/Medicare	1.6%	1.2%	0.0	1.5%	0.9%[a]	–0.1
Private Nongroup	4.6%	2.1%[a]	–0.2	4.3%	4.3%	0.2
Uninsured	4.7%	4.0%	0.0	4.2%	5.2%[a]	0.4

Note: Excludes persons age 65 and older and those in the Armed Forces.
[a] Indicates change in percentages is statistically significant (at the 5% level).
[b] Indicates change in percentages is statistically significant (at the 10% level).

Source: Urban Institute, 2001. Based on data from March Current Population Surveys, 1995, 1999, 2001.

Appendix 3

Children's Health Insurance Coverage by Race/Ethnicity, 1994–2000

	White			Black		
	Coverage Distribution within Income Category		Change in Millions of People	Coverage Distribution within Income Category		Change in Millions of People
	1994	2000	1994–00	1994	2000	1994–00
All Incomes (millions of people)	**48.3**	**48.0**	**–0.3**	**11.7**	**11.8**	**0.1**
Employer	70.8%	75.2%[a]	1.9	41.4%	51.0%[a]	1.2
Medicaid and SCHIP	10.8%	9.8%[a]	–0.5	37.7%	29.7%[a]	–0.9
CHAMPUS/Medicare	1.9%	1.4%[a]	–0.2	2.5%	2.0%	0.0
Private Nongroup	5.7%	4.6%[a]	–0.5	1.9%	2.1%	0.0
Uninsured	10.8%	8.9%[a]	–0.9	16.6%	15.1%[a]	–0.2
Less than 100% of FPL (millions of people)	**7.8**	**6.0**	**–1.8**	**6.1**	**4.6**	**–1.5**
Employer	22.6%	27.7%[a]	–0.1	13.7%	19.3%[a]	0.1
Medicaid and SCHIP	45.5%	41.3%[b]	–1.1	63.6%	55.9%[a]	–1.3
CHAMPUS/Medicare	1.9%	1.6%	0.0	0.7%	1.5%	0.0
Private Nongroup	6.4%	5.8%	–0.2	1.7%	1.5%	0.0
Uninsured	23.7%	23.6%	–0.4	20.3%	21.8%	–0.2
100 to 199% of FPL (millions of people)	**9.0**	**7.6**	**–1.4**	**2.4**	**2.9**	**0.5**
Employer	58.2%	58.4%	–0.8	56.1%	58.3%	0.3
Medicaid and SCHIP	14.4%	20.7%[a]	0.3	18.6%	23.8%[a]	0.2
CHAMPUS/Medicare	3.1%	2.5%	–0.1	4.3%	2.4%	0.0
Private Nongroup	7.0%	5.1%[a]	–0.2	3.0%	2.5%	0.0
Uninsured	17.2%	13.4%[a]	–0.5	18.1%	13.0%[a]	–0.1
200 to 299% of FPL (millions of people)	**9.9**	**8.7**	**–1.2**	**1.3**	**1.8**	**0.5**
Employer	79.0%	78.2%	–1.2	76.7%	70.3%[b]	0.2
Medicaid and SCHIP	2.6%	5.0%[a]	0.1	4.4%	9.6%[a]	0.2
CHAMPUS/Medicare	2.0%	1.8%	0.0	6.1%	3.8%	0.0
Private Nongroup	6.2%	5.8%	–0.1	2.1%	2.6%	0.0
Uninsured	10.2%	9.2%	–0.2	10.7%	13.7%	0.1
300%+ of FPL (millions of people)	**21.5**	**25.7**	**4.2**	**1.9**	**2.4**	**0.5**
Employer	89.9%	90.3%	3.8	86.9%	88.1%	0.5
Medicaid and SCHIP	0.5%	0.9%[a]	0.1	1.9%	2.0%	0.0
CHAMPUS/Medicare	1.3%	0.9%[b]	0.0	3.3%	1.4%[b]	0.0
Private Nongroup	4.7%	3.8%[a]	0.0	1.0%	2.5%[b]	0.0
Uninsured	3.6%	4.1%	0.3	7.0%	6.0%	0.0

	Hispanic			Other		
	Coverage Distribution within Income Category		Change in Millions of People	Coverage Distribution within Income Category		Change in Millions of People
	1994	2000	1994–00	1994	2000	1994–00
All Incomes (millions of people)	**10.4**	**12.6**	**2.2**	**3.5**	**4.2**	**0.7**
Employer	35.5%	42.0%[a]	1.6	57.3%	59.0%	0.5
Medicaid and SCHIP	32.8%	28.5%[a]	0.2	18.0%	18.3%	0.1
CHAMPUS/Medicare	1.2%	0.9%[b]	0.0	3.8%	1.4%[a]	–0.1
Private Nongroup	2.0%	1.8%	0.0	3.9%	3.4%	0.0
Uninsured	28.5%	26.8%[a]	0.4	17.0%	17.8%	0.1
Less than 100% of FPL (millions of people)	**4.9**	**4.7**	**–0.2**	**.9**	**1.0**	**0.0**
Employer	10.4%	14.6%[a]	0.2	15.0%	14.7%	0.0
Medicaid and SCHIP	56.7%	47.7%[a]	–0.5	48.5%	44.6%	0.0
CHAMPUS/Medicare	0.3%	0.9%	0.0	3.7%	2.1%	0.0
Private Nongroup	1.3%	1.2%	0.0	3.9%	2.7%	0.0
Uninsured	31.3%	35.7%	0.1	28.9%	35.9%	0.1
100 to 199% of FPL (millions of people)	**2.8**	**3.8**	**1.0**	**.6**	**.8**	**0.2**
Employer	38.7%	38.8%	0.4	41.1%	52.0%[b]	0.2
Medicaid and SCHIP	19.1%	29.2%[a]	0.6	22.2%	27.9%	0.1
CHAMPUS/Medicare	1.7%	0.9%	0.0	9.4%	1.2%[a]	0.0
Private Nongroup	1.9%	1.6%	0.0	3.4%	1.8%	0.0
Uninsured	38.6%	29.5%[a]	0.0	23.9%	17.1%	0.0
200 to 299% of FPL (millions of people)	**1.2**	**2.0**	**0.8**	**.6**	**.6**	**0.0**
Employer	72.1%	69.1%	0.6	74.4%	68.9%	0.1
Medicaid and SCHIP	5.0%	8.6%[b]	0.2	5.0%	10.2%	0.1
CHAMPUS/Medicare	2.1%	0.7%	0.0	4.1%	1.0%	0.0
Private Nongroup	3.6%	2.6%	0.0	1.5%	2.2%	0.0
Uninsured	17.2%	19.0%	0.2	15.0%	17.6%	0.1
300%+ of FPL (millions of people)	**1.5**	**2.1**	**0.7**	**1.4**	**1.8**	**0.4**
Employer	82.4%	82.1%	0.5	85.1%	83.1%	0.3
Medicaid and SCHIP	2.8%	4.1%	0.0	1.4%	2.5%	0.0
CHAMPUS/Medicare	2.3%	0.9%	0.0	1.4%	1.3%	0.0
Private Nongroup	3.3%	2.9%	0.0	5.1%	4.9%	0.0
Uninsured	9.2%	10.0%	0.1	6.9%	8.2%	0.0

Note: Excludes persons age 65 and older and those in the Armed Forces.
[a] Indicates change in percentages is statistically significant (at the 5% level).
[b] Indicates change in percentages is statistically significant (at the 10% level).

Source: Urban Institute, 2001. Based on data from March Current Population Surveys, 1995, 1999, 2001.

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Enrolling Eligible Children and Keeping Them Enrolled

Donna Cohen Ross and Ian T. Hill

SUMMARY

Coverage under Medicaid and the State Children's Health Insurance Program (SCHIP) provides low-income children with a vital link to needed health care, yet a significant proportion of children eligible for these programs remain uninsured. States have found that expanding eligibility and marketing new programs are not enough to increase enrollment of eligible uninsured children in public health programs. States also need to simplify enrollment and renewal procedures to make them more family-friendly. According to survey data, a key reason for underenrollment is that families find enrollment and renewal procedures too complex.

This article details the efforts that states have made to increase enrollment in Medicaid and SCHIP, and it offers recommendations for strengthening these efforts. Although barriers to enrollment and renewal still exist, states are making progress in several ways, such as:

- Simplifying eligibility procedures.
- Using community-based application assistance.
- Eliminating procedural differences between Medicaid and separate SCHIP programs.

The authors recommend that states continue to simplify program requirements and procedures, making it easier for children to enroll in Medicaid and SCHIP, retain coverage for as long as they qualify, and transfer between programs when necessary. In addition, outreach and community-based application assistance will continue to be essential activities, along with developing efforts to enroll children through other public programs, such as the food stamp program.

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Health insurance can make a striking difference in the lives of children and their families. It not only can influence whether a child obtains needed health care, but it also can affect a child's school attendance and ability to fully participate in school activities.[1] In addition, families that lack health insurance are more vulnerable to financial stress than families with health coverage, making it more challenging for them to meet the needs of their children.[2] For the vast majority (84%) of low-income, uninsured children, Medicaid and SCHIP can provide a vital link to health care, improved participation in school, and greater financial stability.[3] Yet, 6.7 million low-income children who qualify for these programs remain uninsured.[4] States' experiences indicate that expanding eligibility and marketing new programs are not sufficient to reduce the number of uninsured children. To achieve success, a combination of these strategies, supported by ongoing, concerted efforts to facilitate the enrollment of eligible children in health coverage and keep them enrolled, is needed.

Surveys indicate that the complexity of enrollment and renewal procedures has deterred families with eligible children from applying for health coverage. Thus, many children appear to be going without insurance, not because they do not qualify for existing programs, but because their families have difficulty completing forms and assembling the documents that states require them to submit.[5] For example, a national survey found that 67% of low-income families with uninsured children eligible for Medicaid had tried to enroll their children, but only 43% had been successful, largely due to confusion about the process and difficulty producing required documents.[6] Similar procedural barriers impede families from completing the renewal process, causing their children to lose coverage even when they remain eligible.[7]

With the creation of SCHIP in 1997, much attention was focused on the considerable flexibility states had to design new children's health coverage programs that were free of enrollment obstacles. The surge of state activity that followed led federal officials to emphasize that states could also use this flexibility to remove barriers in their existing Medicaid programs, making it easier to coordinate children's health coverage and to conduct outreach, as the law requires.[8]

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Since the implementation of SCHIP, intensive efforts to publicize the availability of health coverage, simplify enrollment procedures, and provide direct application assistance to families appear to have contributed to a significant reduction in the number of uninsured children. Census data show that the number of uninsured children declined by 1.7 million between 1998 and 2000 (from 15.6% to 13.3%). (See the article by Holahan, Dubay, and Kenney in this journal issue for an analysis of uninsurance trends using recent census data.) One reason for this change was an increase in Medicaid and SCHIP enrollment.

Yet, as children's health coverage programs evolve, states continue to grapple with the challenges of enrolling eligible children and keeping them enrolled for as long as they remain eligible. In addition, the need for outreach has not diminished. An analysis of data from the 1999 National Survey of America's Families by the Urban Institute found that although more than 80% of all low-income, uninsured children are now eligible for coverage under Medicaid or SCHIP, the parents of 62% of these children have not heard of the program in their state or do not know that enrollment in welfare is not a precondition for participation.[9] Moreover, the need for outreach is likely to increase further due to increased unemployment, which has caused more children to become eligible for publicly financed health coverage.

This article reviews the strategies states have pursued to achieve strong participation in SCHIP and Medicaid, including simplifying enrollment, reaching out to families, and making it easier for families to renew their children's health coverage. The article also makes recommendations about how states can strengthen their enrollment and retention efforts. Because rigorous studies evaluating specific outreach strategies are largely unavailable, the discussion relies heavily on case studies and telephone interviews with both state officials and representatives of outreach organizations.

Efforts to Simplify Enrollment

Since the late 1980s, states have taken a number of steps that make it easier for low-income families to enroll their children in public health insurance programs. Simplifying eligibility procedures can remove barriers to coverage and make it more likely that children retain coverage for as long as they qualify,[10] produce administrative savings by reducing the time it takes to process applications,[11] facilitate effective outreach by making it feasible for community organizations to assist families with program applications,[12] and help distinguish public health insurance from the welfare system by eliminating onerous procedural requirements that are a vestige of Medicaid's link to welfare.[13]

This section provides a brief history of simplification efforts and discusses common approaches that states have taken to simplify health insurance enrollment for children. Key strategies that states have adopted include designing joint application forms for SCHIP and Medicaid; eliminating asset tests and face-to-face interviews; reducing the amount of proof of eligibility that parents must provide; and offering temporary, immediate enrollment for children while their applications are being processed.

Historical Overview of Simplification Efforts

In the late 1980s, as states adopted significant Medicaid expansions for pregnant women, infants, and young children, they also began to implement a host of federal options aimed at streamlining enrollment. They designed simpler application forms, stopped counting assets (the value of savings and vehicles) in determining eligibility, and authorized providers to presume low-income pregnant women eligible and directly enroll them in Medicaid. During the early 1990s, as expanded Medicaid eligibility for children was phased in, allowing more children to qualify for Medicaid regardless of their family's welfare participation,[14] states continued to simplify enrollment for such children. (See the article by Mann, Rowland, and Garfield in this journal issue.)

By July 1997, 36 states had stopped counting assets in determining Medicaid eligibility for children, and 22 states had removed the face-to-face interview requirement.[15] In addition, states were implementing, to varying degrees, the federal law requiring them to allow applications to be filed at outstation locations in certain hospitals and clinics.[16] Overall, however, applying for Medicaid still looked very much like the process of applying for welfare. Most families had to visit a welfare office, complete long, complicated forms, respond to intrusive questions, submit numerous documents to prove the information provided on the application, and periodically file reports to confirm their ongoing eligibility.

As more and more families with children eligible for Medicaid entered the workforce in the 1990s, due to aggressive "welfare-to-work" initiatives and a strong economy, complying with such procedures became even more problematic for many families. In addition, although Medicaid administrative funds could be used to conduct outreach, efforts to publicize the availability of the program and ways to enroll were rare. Thus, as the nation was on the brink of enacting a major new expansion of children's health coverage under SCHIP, millions of children were eligible for Medicaid but remained uninsured.[17]

Once federal SCHIP funds became available in 1997, most states enthusiastically embraced the new opportunity to provide health coverage to more children. Supported by favorable matching rates and a robust economy, states further expanded eligibility for children's public health insurance and began to design programs with a full menu of simplified procedures that had advantages for both families and state agencies.

Common Approaches to Simplifying Enrollment

By January 2002, most states had adopted critical simplification strategies, such as allowing families to apply for Medicaid and SCHIP on the same form, disregarding assets in determining eligibility, and eliminating

As states have simplified Medicaid and SCHIP enrollment procedures, they also have focused attention on reaching out to families and encouraging them to apply.

face-to-face interview requirements.[18] (See the article by Wysen, Pernice, and Riley in this journal issue.) At the same time, several options that could further simplify the application process were not being used to the fullest extent possible. For example, a minority of states had reduced or eliminated application verification rules not required under federal law or adopted presumptive eligibility for children,[19] and efforts to link children to health coverage when they applied for other public benefits were still in the beginning stages.[20]

One simplification strategy that most states chose to adopt was a common application form for SCHIP and Medicaid. Of the 35 states with separate SCHIP programs, 33 have created joint application forms that families can use to apply for either Medicaid or SCHIP.[21] A single application allows families to apply for health coverage for their children by providing information once and leaves it to program administrators to determine the specific program for which a child qualifies. Indiana reports that the use of a simple joint application for its children's Medicaid and SCHIP program, Hoosier Healthwise, has saved on printing costs and cut in half the time state workers spend verifying information provided by applicants. In addition, the state has realized savings by marketing its Medicaid and separate SCHIP programs as a single, coordinated children's health insurance program.[22]

Most states—44, including the District of Columbia—also do not count assets (such as the value of savings accounts or vehicles) in determining eligibility for children in both their children's Medicaid and separate SCHIP programs. Eliminating asset tests removes questions from the application and reduces the amount of verification states require families to provide. Oklahoma officials report a $1.2 million savings as a result of removing the asset test for Medicaid, since the administrative costs of asset verification exceeded the cost of providing health benefits to children who would not have qualified had assets been counted.[23]

In addition, all but four states no longer require a face-to-face interview as a precondition of enrollment in both their children's Medicaid and separate SCHIP programs. Allowing families to submit application forms by mail, without a face-to-face interview at a government office, can make the process less intimidating and more convenient, particularly for working parents who are hard-pressed to take time off from their jobs to apply and for families with immigrant members who may be reluctant to become involved with a government program. (See the article by Lessard and Ku in this journal issue.)

A growing number of states have taken additional steps to simplify the enrollment process even further. For example, 13 states have eliminated requirements that families provide proof to corroborate the income and eligibility information on their applications (except proof of the immigration status of a noncitizen applying for coverage, which is required under federal law). Generally, these states then verify the income information families provide by cross-checking with data from other government agencies, such as the Social Security Administration and state departments of labor. Such data matching can ensure program integrity while streamlining the enrollment process for families.[24] Other states have reduced the amount of required verification, asking for fewer pay stubs than in the past and not demanding proof of residency or children's birth certificates. Still, various studies indicate that the difficulties families face in gathering all the required documents that states require them to submit contribute to the delay or denial of coverage to otherwise eligible children.[25]

Some states have adopted another simplification option: presumptive eligibility for children. Nine states allow it in Medicaid, and six states allow it in their separate SCHIP programs.[26] Presumptive eligibility allows "qualified entities" such as health care providers, schools, WIC agencies, Head Start programs, certain emergency food and shelter programs, and agencies that determine eligibility for public benefit programs to immediately enroll children who appear eligible for coverage for a temporary period while the family completes the application process. In the meantime, a child can receive all covered services, and providers can be reimbursed for delivering needed

care during the presumptive period, even if the child ultimately is found ineligible for ongoing coverage. (See the article by Klein in this journal issue.)

States can use other strategies to facilitate enrollment in health coverage programs as well. For example, states can explore methods to enroll children in health coverage when they apply for other benefit programs. (See the article by Horner, Lazarus, and Morrow in this journal issue.) More can be done to facilitate development of such approaches and encourage states to implement them.

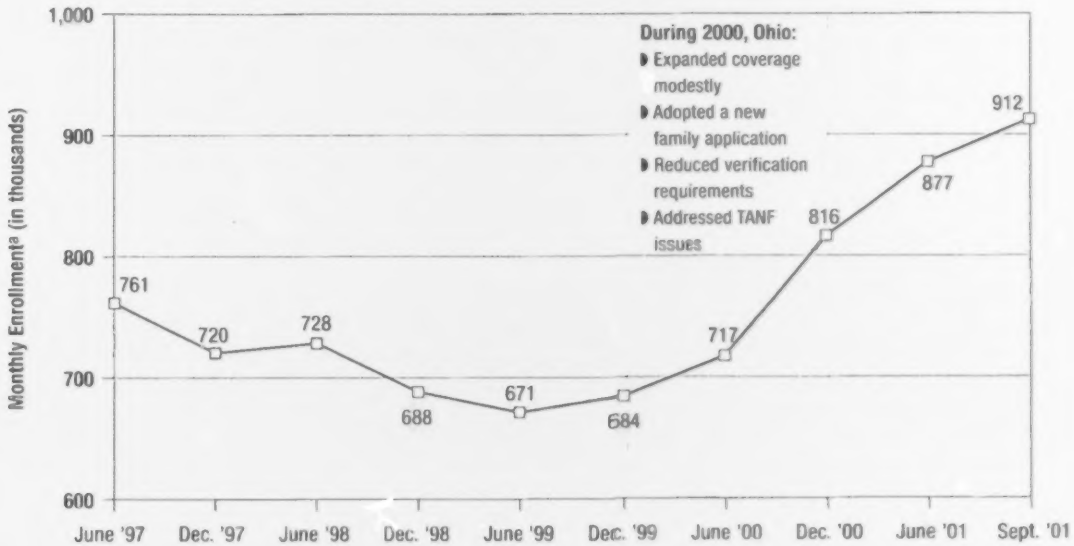
Using strategies like these to simplify enrollment procedures can have a marked effect on enrollment. For example, Figure 1 illustrates the increase in Medicaid enrollment in Ohio following implementation of modest eligibility expansions and a host of simplification measures. In addition to adopting modest coverage expansions in 2000, the state reduced verification requirements, revised its family-based application to allow children and parents to apply as a single unit, and improved systems to assure that families leaving welfare did not lose Medicaid coverage inappropriately. Between June 2000 and June 2001, children's enrollment in the state's traditional Medicaid program jumped by 22%, and combined regular Medicaid and SCHIP-funded Medicaid enrollment grew by 25%.[27]

Reaching Out to Families

As states have simplified Medicaid and SCHIP enrollment procedures, they also have focused attention on reaching out to families and encouraging them to apply for children's health insurance. Community-based application assistance has become a common feature of outreach efforts, with a number of states providing financial

Figure 1

Ohio's Medicaid Enrollment for Children, Families, and Pregnant Women, 1997 to 2001



[a]Reflects enrollment in Ohio's "regular" Medicaid program, which is coverage under Title XIX of the Social Security Act.

Source: Mann, C. *Reaching uninsured children through Medicaid: If you build it right, they will come.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002.

assistance and training to support such activities. A few states also are allowing managed care organizations to participate in enrollment initiatives. Yet, states with separate Medicaid and SCHIP programs still face the challenge of aligning the two programs to make enrollment more consumer-friendly and program administration more efficient. This section describes how states are handling these implementation opportunities and challenges.

Using Community-Based Application Assistance

Using community-based organizations to assist with Medicaid and SCHIP enrollment, providing families with direct help in applying for coverage, can be an important complement to broad outreach and marketing campaigns. Families often have frequent contact and long-standing, trusting relationships with schools, child care providers, faith-based organizations, and health and human services providers. In many communities, staff from these organizations may be the only link to families that are unlikely to apply for coverage on their own, due to a lack of awareness about publicly funded health insurance, difficulties understanding the application process, or a mistrust of government programs. Community organizations may also be in a unique position to reach out to people who do not speak English, have concerns about immigration status, or have work schedules that prevent them from applying at established enrollment sites open only during regular business hours.

Although under federal law only Medicaid agency staff can determine eligibility for Medicaid, staff from community organizations can conduct the initial processing of applications, which includes explaining program rules and benefits and helping families fill out forms, gather required documents, and submit applications.[28] In addition, federal SCHIP regulations allow eligibility determination for separate SCHIP programs to be performed by a wide range of entities, as determined by the state.[29]

States have supported the growth of community-based application assistance with a combination of grants, contracts, and training. Widespread support for community application assistance is evident across the country.[30] Some states, including Illinois, Indiana, and New Mexico, have established enrollment sites in hundreds of locations and in a wide variety of settings, such as health clinics, schools, Head Start programs, recreation centers, and homeless shelters. To enable community groups to conduct aggressive outreach and enrollment activities, other states, including California, Massachusetts, New Jersey, Ohio, and Pennsylvania, offer grants or pay application-assistance fees of $20 to $50 for each application that results in an enrolled child.[31]

In the early years of SCHIP's implementation, some community organizations found application-assistance efforts too time-consuming to sustain and, as a result, stopped providing such assistance.[32] As states have further simplified application procedures, however, community-based application assistance has become a more effective and popular outreach tool. For example, a project run by the Baltimore City Health Department, which helps enroll children in the Maryland Children's Health Program, found that application-processing time was significantly reduced after the state implemented a self-declaration-of-income policy. Outreach workers who had previously spent a great deal of time helping families gather necessary documentation were able to spend more time recruiting new families through door-to-door canvassing and identifying eligible children in Head Start programs and schools.[33]

Despite the growth in community-based application assistance, many children's health insurance applications still are submitted incomplete. For example, in California, state officials reported in mid-2001 that roughly 70% of applications were submitted incomplete, meaning that information, a parent's signature, or a verification document were missing.[34] A state report indicates that between July 2001 and June 2002, roughly 44% of children's health coverage applications remained incomplete 20 days after they were submitted.[35] The help provided by community application assistants, however, did appear to make a difference in California: 63% of applicants who received no assistance were approved for enrollment, compared to a 79% approval rate for families who received assistance.[36]

In addition, lessons learned by community-based organizations engaged in outreach and enrollment activities can help inform ongoing simplification efforts. For example, in 1999, initial attempts to reach out and enroll children in Illinois' KidCare program through a Report Card Pick-Up Day enrollment campaign in the Chicago public schools yielded poor results. Of the 4,600 applications received, only about 1,000 were approved.[37] Feedback

from school employees and community groups enlisted to help implement the event revealed that families were daunted by a difficult-to-understand 12-page application. In response, the application was reorganized and shortened to 3 pages, and it was made clear that adults applying for coverage for only their children did not have to provide their own Social Security numbers.

Involving Health Organizations in Marketing and Enrollment

Enlisting managed care organizations (MCOs) and individual health plans as partners in outreach and enrollment initiatives offers opportunities, but also raises concerns about potential conflicts of interest. During the 1980s and 1990s, in the early years of Medicaid managed care implementation, states identified instances of abusive marketing practices by MCOs as they sought to attract Medicaid recipients.

To prevent abuses, states have adopted practices designed to carefully regulate these organizations' activities. For example, to protect beneficiaries' access to information and their freedom of choice in selecting a health plan, states commonly prohibit organizations from conducting door-to-door marketing, using enrollment gifts or incentives, marketing in food stamp and welfare offices, and providing inaccurate information to potential enrollees. In addition, many states have hired "enrollment brokers" to oversee the fair and systematic enrollment of Medicaid eligibles into managed care.[38,39]

Yet, the prospect of using MCOs' marketing skills and resources to help children enroll in public health insurance programs is attractive to some states, and several have enlisted the assistance of MCOs and health plans in SCHIP and Medicaid outreach and enrollment efforts. Case studies of 10 states conducted in 2001 and 2002 found that one-half of the states permit health plans to produce and disseminate advertisements for SCHIP and Medicaid that identify these plans as participating providers. All television, radio, and printed marketing materials, however, must be submitted to the state for review and approval. In two of these five states, California and New York, health plan staff are permitted to provide application assistance to prospective enrollees[40] (see Box 1).

Aligning Enrollment Procedures in Dual-Program States

States that created separate SCHIP programs designed their new systems with a wide range of simplified procedures, such as eliminating face-to-face interviews, asset tests, and family income verification. These strategies are also allowed under federal Medicaid law; however, states have not always simplified the process for children in Medicaid to the same extent as in SCHIP.[41] Given that more than two-thirds of uninsured, low-income children

Box 1

Partnering with Managed Care Organizations in Marketing and Enrollment Efforts in New York

Managed care plans are key partners in New York's marketing and enrollment strategies. This approach began in the early 1990s when the state-funded Child Health Plus program relied exclusively on managed care plans to enroll eligible children, and was continued when the program began receiving federal matching funds under SCHIP. As of 2002, virtually all participating health plans had contracts with the state to serve as "facilitated enrollers." Health plan staff can assist families in completing the Child Health Plus application form, and must screen children for both SCHIP and Medicaid eligibility, referring applications of those children who appear Medicaid eligible to the appropriate county social services agency.

Source: Hill, I., Hawkes, C., and Harrington, M. *Congressionally mandated evaluation of SCHIP: Final cross-cutting report on the findings from 10 state site visits.* Washington, DC: U.S. Department of Health and Human Services, forthcoming.

are eligible for "regular" Medicaid, not SCHIP, simplifying the Medicaid program needs further attention.[42]

Aligning the two programs makes enrollment easier for families and for states and can help some families overcome their concerns about participating.

Making Enrollment Easier

In states where the enrollment procedures for Medicaid and SCHIP are not aligned, families face added barriers to gaining coverage, with the larger burden often falling on families with children eligible for Medicaid. Families applying for the SCHIP program whose children turn out to be eligible for Medicaid may be asked to submit additional paperwork and undergo greater scrutiny to complete the Medicaid eligibility process. In addition, in states where Medicaid income-eligibility limits vary by the age of the child,[43] children in the same family may be eligible for different programs. In such situations, families may have to navigate two sets of program rules and procedures to obtain coverage for all their children, a complication that can override the advantages of a joint application. Once enrolled, families may have to abide by two sets of reporting requirements and respond to correspondence from two different agencies regarding different enrollment periods and renewal schedules. Bringing all children in a family into the same health insurance program could help prevent such complications and could substantially improve the degree to which children in the family receive uninterrupted health care.

States can use their broad flexibility to create Medicaid programs that feature the same simple, streamlined procedures used in separate SCHIP programs. Moreover, states can assure that all children are covered under the same program by using the authority they have under Medicaid law or by using SCHIP funds to expand Medicaid beyond the minimum thresholds to establish a uniform Medicaid income-eligibility limit for all children through age 18.

Abolishing procedural differences between Medicaid and separate SCHIP programs also makes it easier for states to administer the programs and allows them to more effectively meet their responsibility to determine the appropriate program for children applying for benefits. Under federal law, states are required to screen all children who apply for coverage under the separate SCHIP program to identify those who appear to qualify for Medicaid, and children found eligible must be enrolled in Medicaid.[44] This rule has become known as the "screen and enroll" requirement. (Federal SCHIP regulations also require state Medicaid agencies to adopt a process that facilitates enrollment in the state's separate SCHIP program when a child is found ineligible for Medicaid at initial application or redetermination.[45]) Effective screen and enroll procedures help prevent children from losing out on coverage if a parent applies to the "wrong" program and also ensure that children eligible for Medicaid are able to receive the full benefits and cost-sharing protections that the program provides. The procedures also permit the smooth transfer of children from one program to the other if their family circumstances change.

A number of states with separate SCHIP programs, including Indiana, Kentucky, Massachusetts, and North Carolina, have taken steps to align their SCHIP and Medicaid programs. They use similar methods to count income in determining Medicaid and SCHIP eligibility, have similar enrollment procedures, and allow eligibility workers to determine eligibility for either program.[46] Other states have improved coordination by screening applications for Medicaid at a central location and then forwarding them to the proper place for final eligibility determination. In Florida and Texas, the transfer occurs

electronically; in Kansas and New Jersey, applications that appear eligible for Medicaid are transferred to colocated Medicaid eligibility workers for a final determination.[47]

Some Families' Concerns about Participating

Concerns have been raised that some families' resistance to enrolling their children in Medicaid could adversely influence the effectiveness of the SCHIP screen and enroll process. This resistance may stem from a number of concerns, including the belief that the Medicaid enrollment process is difficult to complete or intrusive, fear on the part of families with immigrant members that enrolling in Medicaid will jeopardize their immigration status, worries about the availability of providers or that providers will give substandard treatment, or the belief that Medicaid participants are not treated with respect, generally referred to as "stigma."[48] In key informant interviews conducted as part of SCHIP evaluations, outreach staff and family advocates report that some parents feel intimidated or encounter rude treatment by local social services staff. In addition, fears about being a "public charge," and the misconception that participation in Medicaid or SCHIP will hurt applications for citizenship, may be more pronounced in states with large immigrant populations.[49] However, a study of community health center patients in 10 states found that, among these barriers, the most significant in terms of deterring families from applying for Medicaid were those associated with the application process or confusion about Medicaid eligibility.[50]

While some of these concerns may prompt potential beneficiaries to indicate they do not wish to enroll their children in a program, when families are given a better understanding of the program and application process, they often reconsider and go forward with their applications. In California, for example, where the joint Medicaid/SCHIP application contains a check box (sometimes called an "opt-out box") for families to indicate if they do not want their applications forwarded to Medicaid or Healthy Families (the state's separate SCHIP program), between June 2001 and June 2002, about 30% of families indicated they did not wish to have their applications forwarded to Medicaid.[51] Community-based application assistants report that they are often successful in allaying parents' fears about Medicaid, dispelling misconceptions about the program, and persuading parents to enroll their children. Most often, the factors that help persuade parents to follow through with Medicaid enrollment are that they do not need to go to a county social services office to apply (but instead can complete the process by mail) and that they do not necessarily need to change doctors as a result of enrolling in Medicaid.[52]

In Georgia, where the joint Medicaid/SCHIP application formerly contained an opt-out box, families with children who appeared to be eligible for Medicaid, but had opted out, received a personal call from a Right from the Start Medicaid (RSM) eligibility worker, who explained the benefits of Medicaid. According to RSM, between March 2000 and July 2000, only 460 families out of 7,425 applying for PeachCare—about 1 in 17—checked the Medicaid opt-out box. After a call from an RSM worker, 260 of these families decided to complete the application process.[53] Responding to concerns that opt-out boxes may communicate misleading messages about coverage programs (for example, possibly implying incorrectly that Medicaid and SCHIP have the same benefits), all but one of the five states that initially had opt-out boxes eliminated them.

Despite the concerns expressed about participating, research also indicates that families with eligible children consider Medicaid to be a good program and would like to enroll their children. For example, a national survey of low-income parents found that the vast majority of parents of both Medicaid-enrolled and -eligible uninsured children agreed that Medicaid is a good program (94% and 81%, respectively).[54] In addition, more than 9 in 10 parents of eligible uninsured children (93%) appeared willing to enroll their children in Medicaid. Another study conducted in California found that 70% of English-speaking Latino parents and 63% of Spanish-speaking Latino parents said they would enroll their children in Medi-Cal (the state's Medicaid program) if the children were found eligible.[55]

Many states tell much the same story in analyzing their experiences with SCHIP, reporting that the steps they have taken to improve Medicaid's processes, marketing, and coverage strongly contributed to their enrollment gains.[56] Given the research demonstrating that the barriers to enrollment are largely related to process and are not inherent to the program itself, states could use their broad flexibility to re-create Medicaid programs that feature the same simple, streamlined procedures used in sep-

arate SCHIP programs. In doing so, they could allay many of the fears expressed by families who may be reluctant to apply. Moreover, community outreach efforts can be instrumental in helping families—particularly those that have had difficulty applying for Medicaid in the past or those with particular concerns, such as immigrants—understand new, improved procedures.

Addressing Eligibility Renewal

Enrolling children in SCHIP and Medicaid is only the first step in giving them access to health care. Policymakers also must ensure that eligible children do not lose coverage because of difficulties in renewing their health insurance. States have adopted a number of strategies for easing eligibility renewals, but despite these steps, significant barriers keep many families from renewing their children's health coverage.

Keeping Children Enrolled: A Continuing Challenge

Typically, states' eligibility redetermination processes under SCHIP and Medicaid work as follows: Between 60 to 90 days before the renewal date, computerized eligibility systems send notices to parents, informing them that their children need to reestablish eligibility. These notices also may instruct parents that they must complete a renewal form, usually enclosed with the notice, and attach income verification. This initial contact may be followed up by one or more reminder notices or postcards; a few states make personal or telephone contacts. If the family's renewal form and documentation are not received, its children are automatically disenrolled at the termination date.

The problem of "churning" among children on Medicaid—that is, when children are disenrolled when the renewal process is not completed, only to be reenrolled when parents learn of the disenrollment or when the children next need health care—has been well documented.[57] Nevertheless, state officials did not fully anticipate potential retention problems when designing their SCHIP programs, placing more emphasis on designing streamlined enrollment policies than on designing simple eligibility redetermination processes.[58] As a result, SCHIP programs also experienced considerable churning during the early phases of implementation.

As early as mid-1999, when children in many states were reaching the end of their first annual SCHIP eligibility cycle, anecdotal reports from states indicated that large proportions of children were losing their eligibility or disenrolling.[59] Research has since confirmed the extent of the problem. One study found that four of the five states examined were retaining less than 50% of children who were up for renewal,[60] often because parents were unable to complete the redetermination process or did not respond to state renewal notices.

At the same time, state officials have struggled with the question of what a reasonable rate of retention under SCHIP should be. Because the program is explicitly designed to serve children of low-income workers, whose hours and employment status fluctuate, many enrollees may lose eligibility when their parents obtain new jobs that provide health benefits, or when their parents lose income, thus making the children eligible for Medicaid.

More recent evidence indicating high rates of disenrollment, however, has raised concerns. For example, a study found disenrollment rates of about 50% or higher at renewal time in three of the four states studied, noting further that roughly 25% of disenrolled children reenrolled within two months.[61] The finding that many families obtained coverage again so soon after disenrollment suggests that their children were probably dropped even though they remained eligible. Still unknown is how many of the children in families that did not attempt to reenroll also may have been eligible at the point of disenrollment. Concerns that many eligible children may be losing coverage at the point of renewal has made SCHIP and Medicaid retention a high priority for federal and state policymakers, as well as advocates and community-based organizations.

State Strategies for Simplifying Renewal Policies and Procedures

The attention focused on problems with retention, coupled with guidance from the federal level on facilitating renewal procedures,[62] has spurred an increasing number of states to simplify their eligibility renewal processes. State efforts to simplify renewal policies and procedures vary widely. Some of the more promising approaches are described below.

Less Frequent and "Off-Cycle" Renewal

A national survey of enrollment and renewal procedures in children's health coverage programs found that 42 states, including the District of Columbia, allow families to renew coverage for their children under Medicaid and separate SCHIP programs every 12 months, as opposed to requiring families to renew children's health coverage more frequently.[63] At least one state, Massachusetts, allows parents to renew children's coverage early, or "off cycle," when it is more convenient to do so (see Box 2). Seventeen states also have adopted 12-month continuous eligibility, which guarantees a full year of coverage regardless of fluctuations in family income or other circumstances, for children in Medicaid and separate SCHIP programs.

No Face-to-Face Interview

In addition, the survey found that almost all states—48, including the District of Columbia—no longer require a face-to-face interview with an eligibility worker when parents renew children's public health coverage.[64] As with initial applications, mail-in renewal applications are more convenient and desirable for parents who work or who might be uncomfortable visiting a county welfare or Medicaid eligibility office.

Joint Renewal Forms

The lack of coordination between SCHIP and Medicaid eligibility renewal processes can create significant problems for families. Many states are applying their successes with joint SCHIP and Medicaid application forms to the renewal process. Of the 35 separate SCHIP programs, 21 allow families to use a joint form to renew coverage in both SCHIP and Medicaid.[65] Joint renewal forms save families from having to submit multiple renewal applications if changes in income or other circumstances require a shift in coverage from SCHIP to Medicaid, or vice versa, or if families have children in different programs.

Less Onerous Verification Requirements

Some states have reduced the amount of verification they require at renewal, often requesting only documentation of current income, or allowing families to self-declare

Box 2

"Member Express Renewal" Helps Families Retain Coverage in Massachusetts

Massachusetts has supported intensive efforts on the part of community organizations to help get children enrolled in the state's Medicaid and SCHIP programs, collectively known as MassHealth. Considering the investment in outreach, state officials and advocates were disappointed to learn that a large proportion of families—about 20%—were not responding to renewal notices at the end of the 12-month coverage period. As a result, large numbers of children were losing coverage even though they were likely to still qualify.

In response, health care administrators in Massachusetts decided to apply the advances of community-based assistance to the renewal process. With funding from the federal Centers for Medicare and Medicaid Services, a procedure termed "Member Express Renewal" was developed in which some families can opt to renew their coverage "off cycle," that is, before their scheduled redetermination date, when they visit a community clinic or other community location. For example, if a child were determined eligible on January 1, 2002, he or she would not be due to renew coverage until January 1, 2003. But, if the child were scheduled for a pediatric care visit in September 2002, the parent could fill out a simple form in the clinic waiting room and the child's eligibility could be extended until September of the following year.

To date, the results have been encouraging. Recent data show that of the families permitted to renew via the "Member Express" process (some beneficiaries, such as those also on food stamps, are not permitted to do so), 100% received continued coverage.

Source: Correspondence with Joshua Greenberg, Health Care for All, Boston, MA, February 6, 2002.

Many states still require families to resubmit extensive information and documentation to renew their children's health insurance.

their income.[66] In addition, some states have begun to preprint their renewal forms, for SCHIP in particular, with some or all applicant information collected during the initial application. Families are required to update only existing information that has changed.

Automatic or "Passive" Renewal

Changing the "default" action to continued coverage, rather than disenrollment, for families that do not respond to renewal notices offers an even simpler approach to eligibility renewal. For example, Florida conducts what it calls "passive renewal" under SCHIP. The state's data system generates a preprinted renewal form, which families are required to return only if any information has changed. A "nonresponse" is presumed to indicate that nothing on the application has changed, and therefore the child remains eligible. It is important to note that Florida's SCHIP program requires the payment of monthly premiums as a condition of ongoing eligibility. Therefore, state officials assume that if parents are contributing to the cost of their coverage on a monthly basis, they must be living in the state and participating in the program.

Recent research has demonstrated the benefits of Florida's policy. While large drops in enrollment—about 30% to 50%—were found in three states with more traditional renewal procedures, in Florida, disenrollment at renewal was only 5%. Thus, the passive renewal procedure can sharply reduce disenrollment.[67] South Carolina has introduced a similar process in its Medicaid program.

Addressing Barriers to Renewal: Areas for Improvement

Although the state experiences presented here demonstrate that efforts to facilitate ongoing coverage and simplify eligibility renewal appear to be working, case studies and discussion with state and local officials indicate that barriers to reenrollment still need to be addressed. (See Box 3.)

Relying on a Mail-Based System

Most states send families notices and postcards reminding them to renew eligibility. These notices often use confusing bureaucratic language, and many state and local officials suspect that such language often results in nonresponses that lead to disenrollment.[68] Many officials believe that following up by phone or with in-person reminders might yield a better response rate. For example, county offices in North Carolina follow up with personal phone calls to remind families about their renewal deadlines, and in New York, the Bronx Health Plan (which participates in the state's SCHIP program, Child Health Plus) makes home visits to remind families of the need to renew eligibility.[69] In both of these states, these follow-up strategies have reportedly reduced rates of disenrollment.[70] In addition, state and local officials interviewed during case studies as part of national evaluations of SCHIP have speculated that grace periods might allow children to retain eligibility while enrollment entities conduct follow-up with nonresponding families.

Requiring Families to Resubmit Information and Documentation

Many states still require families to resubmit extensive information and documentation to renew their children's health insurance, even though federal guidance issued in August 2001 emphasized that states have the options of using preprinted renewal forms and reducing verification requirements.[71] The federal government also requires states to conduct reviews of ongoing eligibility using information that is already available to the state to the extent possible ("ex parte eligibility reviews"). By conducting such ex parte reviews, using program records from food stamps, TANF, subsidized child care, or wage-reporting databases, states can simplify administration and reduce the risk that a family with an eligible child will not complete the renewal process and thus be inappropriately denied coverage. (See Box 4.) Currently, however, no national data are available on the extent to which states conduct ex parte reviews.

Charging Premiums

Most states with separate SCHIP programs charge premiums, which may make parents less likely to renew their children's coverage. Imposing premiums has been shown to have a negative effect on enrollment in subsidized health insurance programs,[72,73] but less is known about the extent to which premiums affect rates of

retention and families' decisions regarding whether or not to continue children's coverage. One study found that failure to pay premiums accounted for no more than 2% of all renewal outcomes among five states studied.[74] On the other hand, a study by the U.S. General Accounting Office found that up to 10% of children enrolled in SCHIP lost coverage due to their parents' failure to pay premiums.[75] In addition, a case study of New York found that children in the premium-paying categories under Child Health Plus churn more regularly than children whose parents do not pay premiums.[76] Some health plan officials believe that many premium-paying parents allow their children's coverage to lapse when children are healthy and then reenroll them when medical care is needed.[77] In most states, however, data do not permit officials to conclude whether disenrollment for nonpayment of premiums is due to the affordability of those premiums or to some other reason, such as a family moving out of state or a parent getting a new job with health benefits.[78]

More generally, current data systems limit the ability to accurately measure retention and thus understand the factors that may contribute to retention problems. Recent research has found that SCHIP and Medicaid data systems are highly variable, and often quite limited, in their capacity to report on outcomes of the eligibility renewal process.[79] Some states do not collect data on eligibility redeterminations per se; rather, these states maintain broader "case closure" databases that compile information on all closures, whether or not they occur at renewal. Even among those states that do maintain records specific to redetermination, the codes, definitions, and classifications of various data elements vary dramatically, thereby making aggregation and cross-state comparisons very difficult, if not impossible.

Considerations for the Future

The current environment is challenging for children's health insurance programs. Because of an economic downturn that began in 2001, states have come under

Box 3

Strategies to Improve Retention in Louisiana

In Louisiana, improving retention started in 2001 with the development of systems to track the reasons why children were losing coverage. Computer codes were initially vague, indicating that cases were closed for "failure to cooperate." New codes were established to provide more explicit information, such as "failed to return form," "failed to return verification," or "mail not delivered." Another beginning step was to change the vocabulary used in forms, manuals, and in conversation with program participants. "The word 'redetermination' is welfare-speak," said one state official. "The term 'renewal' makes more sense to families and is a lot friendlier."

The state then piloted a host of new strategies which now have become part of the renewal process. Caseworkers first search the computer to see if children are receiving other benefits, such as food stamps. If they are, then family income is automatically verified and health coverage is continued. For families whose health coverage cannot be continued automatically, the state created a new, simple renewal form. Although families are asked to return proof of income with the form, if the form is returned without it, coverage will not be terminated if wage information available from the Department of Labor confirms that the child still qualifies. Finally, the state is taking steps to track the performance of local Medicaid offices to ensure caseworkers understand and follow these new procedures.

This concerted effort to assure that children retain health coverage for as long as they remain eligible is showing success. According to state data, case closures for procedural reasons have declined from around 25% to less than 10%.

Source: Correspondence with Ruth Kennedy, Louisiana Department of Health and Hospitals, February 2, 2002.

Box 4

Using Information from Food Stamp Reviews to Automatically Renew Medicaid in Washington

In Washington State, county community service offices (CSOs) automatically renew health coverage for children in families that have an open case for other benefits such as food stamps, using the latest information the family has supplied to the food stamp program. When the family comes in for a food stamp eligibility review, the caseworker automatically performs a Medicaid review at the same time. If eligible, the child is certified for 12 months of coverage and does not have to go through the Medicaid renewal process at the original 12-month mark. The next Medicaid renewal date would be scheduled 12 months from the food stamp review, extending coverage for the child and reducing administrative burdens on the family and the state agency. After this policy and others were implemented, Washington's Medicaid retention rate for children who also had food stamps improved dramatically.

Source: Conversation with David Hanig, Washington Department of Social and Health Services, February 2002.

serious pressure to curb spending, and many are considering a range of measures to limit enrollment in their Medicaid and SCHIP programs, including retracting eligibility, freezing enrollment, and curtailing high-profile media campaigns. Some states already have begun such actions. At the same time, the need for public insurance programs likely has increased. Many working families have lost jobs or have had work hours cut back and, as a result, may have lost their employer-based coverage or their ability to pay out-of-pocket costs associated with health coverage.[80] Parents whose children now qualify for coverage under SCHIP or Medicaid will need to obtain health coverage for their children without delay.

Prompt enrollment in Medicaid or SCHIP ensures continuity of care for a child with current medical needs and protects families from financial exposure should a medical need arise. Preserving simplified procedures and outreach efforts will help eligible children gain access to existing health coverage programs and help reduce the degree to which elevated unemployment causes an increase in the number of uninsured individuals.

Some specific simplification steps are of particular importance. For example, states can take steps to:

- **Ease transfers between Medicaid and SCHIP.** State procedures should allow children to transfer smoothly from the state's separate SCHIP program into Medicaid if financial hardship warrants the change. A shift into Medicaid would relieve eligible families of any cost-sharing requirements imposed by the SCHIP program and would ensure families the benefit package and other protections the Medicaid program provides. Families should be apprised that such a transfer is possible when the need arises, even if a child is in the midst of the SCHIP enrollment period, and families should not have to submit a new application, although documentation of their new income may be requested.

- **Eliminate waiting periods.** Although federal regulations do not require it, many states impose waiting periods in their children's health coverage programs in an effort to discourage "crowd-out," or the substitution of public coverage for private insurance. In states that have waiting periods, children are required to be uninsured for the duration of the waiting period before they are allowed to apply for public coverage. While states with waiting periods generally exempt children whose parents have lost employer coverage through no fault of their own, this protection does not usually extend to families who find the premiums charged by private plans to be unaffordable. Children subject to

waiting periods may experience harmful gaps in coverage that can be particularly problematic for children with urgent or chronic medical conditions.

To reduce the potential dangers of coverage gaps, states can eliminate waiting periods or shorten their duration. Alternatively, following the lead of states like California, Colorado, Connecticut, Michigan, New Jersey, Texas, and Washington, states may exempt from waiting periods families whose children are covered by costly individual policies or whose premiums are considered unaffordable. Or, like North Carolina, states may opt to exempt children with special health care needs from waiting periods.[81] Presumptive eligibility can also speed the enrollment of children who appear to qualify for SCHIP or Medicaid, allowing their parents time to gather documents the state requires before children can be enrolled.

- **Enroll children through other benefit programs.** Because most of the information needed to make a health coverage eligibility determination is collected when a family applies for other programs, states need to take affirmative steps to ensure that children are linked to Medicaid and SCHIP when their families seek other assistance. Families affected by increased unemployment are likely to rely on public benefits to help them weather hard times. From October 2000 to October 2001, for example, the number of food stamp participants increased by 1.4 million,[82] and approximately three-quarters of food stamp households include children. Thus, procedures to enroll children in Medicaid or SCHIP when their families apply for food stamps could help ensure that children's health needs are met when their families are under financial stress.

- **Implement easy renewal procedures.** During an economic downturn, it is particularly important to help families retain Medicaid and SCHIP coverage for as long as they are eligible, since they are less likely to be leaving the program because they have found private coverage through an employer. Families should be able to complete the renewal process easily, by mail, and without having to produce information that has not changed since the initial application.

- **Continue outreach and public information.** Although states may be under pressure to dispense with the health insurance public education and media campaigns that have been popular over the past several years, outreach will continue to be crucial during hard economic times. A national survey by the Urban Institute found that, in 1999, almost two-thirds (62%) of parents of low-income, uninsured children were either not aware of any child health insurance program in their state or did not know that enrollment in welfare was not a precondition for participation.[83] Although extensive outreach in recent years has presumably increased families' awareness of both Medicaid and SCHIP, it is likely that many newly unemployed families with long-standing stable work histories or employer-based coverage will need information about available public coverage. Outreach messages can be crafted especially for this new audience, alerting them to the availability of Medicaid and SCHIP for their children and to the possibility of obtaining coverage for parents.

Over the past five years, states have made substantial gains in making health coverage available to uninsured children and facilitating their enrollment. Yet, continued efforts to simplify enrollment and renewal procedures and to align Medicaid and SCHIP rules are needed to ensure that the programs reach their full potential. A weakening economy could lead states to enact eligibility cuts or procedural changes that could undermine the progress achieved in reducing the numbers of uninsured children. The challenge now is to sustain the progress that has been achieved and to continue to advance efforts to ensure that eligible children and parents are aware of and able to obtain available health coverage.

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59. National Governors' Association, Center for Best Practices. *Retention and reenrollment of children in SCHIP and Medicaid*. Washington, DC: NGA, September 1999.

60. See note 58, Hill and Westpfahl-Lutzky.

61. See note 25, Dick, et al.

62. See note 8, Centers for Medicare and Medicaid Services.

63. See note 10, Cohen Ross and Cox.

64. See note 10, Cohen Ross and Cox.

65. See note 10, Cohen Ross and Cox.

66. See note 58, Hill and Westpfahl-Lutzky; Bachrach, D., and Warnke, S. *Memo on key provisions in 2002/2003 health care package (S. 6084/A. 9010)*. New York, NY: Kalkines, Arley, Zall, and Bernstein LLP, January 17, 2002.

67. See note 25, Dick, et al.

68. See note 58, Hill and Westpfahl-Lutzky.

69. See note 58, Hill and Westpfahl-Lutzky.

70. For additional information, see Tassi, A., and Bachrach, D. *The Medicaid recertification assistance demonstration*. Princeton, NJ: Center for Health Care Strategies, Inc., April 2002.

71. Regulations provide that the scope of eligibility reviews must be limited to information that is necessary to determine ongoing eligibility and is related to circumstances that are subject to change. States may not require families to provide information that is not relevant to ongoing eligibility or that has already been provided and is not subject to change, such as documentation of the date of birth of a child.

72. Ku, L., and Coughlin, T.A. *The use of sliding scale premiums in subsidized insurance programs*. Washington, DC: Urban Institute, March 1997.

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74. See note 58, Hill and Westpfahl-Lutzky.

75. U.S. General Accounting Office. *Medicaid and SCHIP: States' enrollment and payment policies can affect children's access to care*. Washington, DC: GAO, September 2001.

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77. See note 76, Hill and Hawkes.

78. See note 58, Hill and Westpfahl-Lutzky.

79. See note 58, Hill and Westpfahl-Lutzky.

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Special Populations

EDITOR'S INTRODUCTION

A challenge for any health insurance program, public or private, is reaching and serving the most vulnerable groups of children. Difficult-to-serve children tend to fall through the cracks of systems that provide adequate coverage for most other children. The "Special Populations" section focuses on the particular challenges of providing health coverage to three groups of children: immigrant children, adolescents, and children with special health care needs. Both immigrant children and adolescents tend to be overrepresented among the 9 million children who remain uninsured. For example, high rates of uninsurance persist among immigrant children despite the fact that most are eligible for public programs. Adolescents, who were initially excluded from public coverage, are also less likely to have coverage than younger children. Although children with special health care needs tend to have insurance coverage, their frequent use of health care services provides an important test of the programs' effectiveness in meeting children's health needs. The articles in this section describe the unique characteristics of these three groups of children, the gaps in their coverage, and efforts to improve their access to appropriate care.

The first article, by Lessard and Ku, notes that one of the most important risk factors for lack of health coverage is a child's family immigration status: About one-third of the nation's low-income, uninsured children live in immigrant families. Furthermore, because children of immigrants constitute a growing share of all American children and are increasingly dispersed across the United States, their health has become an issue of national concern. The article describes the barriers to health care that these children face, such as limited federal eligibility, and language and cultural barriers. Several solutions are explored, including restoring and expanding federal eligibility rules for Medicaid and the State Children's Health Insurance Program (SCHIP) without regard to a child's immigration status, providing language assistance, and developing culturally appropriate outreach efforts.

The second article, by Brindis, Morreale, and English, explores why adolescents (defined as young people ages 10 to 19) are less likely than younger children to have health coverage. As

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the authors note, about one in every seven adolescents has no health insurance. Lack of insurance coverage among adolescents is a concern because, as the authors explain, access to care during this critical developmental period helps prevent the onset of unhealthy, risky behaviors that can lead to chronic health problems. During adolescence, children experience a number of changes—physical, emotional, and cognitive—and their health needs differ from those of younger children. For example, adolescents may need services for health issues such as pregnancy or substance abuse. The article describes several strategies for improving access to health care for adolescents by developing specialized outreach materials and providing specific information about confidentiality protections.

In the third article, Szilagyi examines how well public health programs meet the needs of children requiring special care (broadly defined as children with chronic physical, mental, developmental, or behavioral needs who may require special services). With their consistent patterns of high need and use of services, children with special health care needs are expensive to serve. A recent survey indicates that although children with special needs represent a relatively small proportion of the total population of American children (12% to 14%), they account for almost 50% of all health care expenditures. While most children with special needs have good access to care and good relationships with health care providers, a significant portion do not. For example, nearly one in ten lacks a usual source of care, and about one in five has difficulties with referrals. Strategies for strengthening public programs for children with special needs include broadening benefits, ensuring adequate provider networks, increasing collaboration and coordination across programs that serve these children, and eliminating the mandatory waiting period under SCHIP.

By providing some insight into the challenges involved with providing health coverage for these uniquely vulnerable groups of children, these articles underscore the necessity of designing public programs that provide health coverage for children who sometimes encounter greater obstacles to receiving needed health services.

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Gaps in Coverage for Children in Immigrant Families

Gabrielle Lessard and Leighton Ku

One in every five American children is a member of an immigrant family.[1] Despite their substantial numbers, these children are much less likely to have health insurance and ready access to health care than children in native-born citizen families. Family immigration status is, in fact, one of the most important risk factors for the lack of health care coverage among children in the United States. About one-third of the nation's low-income,[2] uninsured children live in immigrant families (see Figure 1). Almost all of these children meet the income requirements for eligibility for Medicaid or the State Children's Health Insurance Program (SCHIP), but for various reasons they are not enrolled. For example, some of these children are ineligible for Medicaid and SCHIP because of immigrant eligibility restrictions. Many others are eligible but not enrolled because their families encounter language barriers to enrollment, are confused about program rules and eligibility status, or are worried about repercussions if they use public benefits. Not only are children of immigrants more likely to be uninsured and less likely to gain access to health care services than children in native families, but communication barriers can also result in immigrant children receiving lower-quality services.

The linguistic, cultural, legal, and socioeconomic circumstances of immigrants pose special challenges and opportunities for policy officials and health care practitioners seeking to provide health care and health insurance coverage to children in immigrant families. And because children in immigrant families constitute such a large share of the nation's uninsured, successfully reducing the total number of uninsured children depends in large measure on how well the needs of immigrant families are addressed. Furthermore, immigrants are increasingly a concern for every state. Although immigrants traditionally have been concentrated in a handful of states—California, Florida, New Jersey, New York, and Texas—an increasing number are relocating throughout the country in pursuit of employment. Seventy percent of immigrants still reside in California, Florida, New Jersey, New York, and Texas, but the immigration growth rate during the 1990s was highest in southern and central states such as Iowa, Nevada, North Carolina, and Virginia.[3] Health care and social service providers across the country are learning how to adjust their services to accommodate the needs of immigrant families.

Federal, state, and local policies and practices can either promote or undermine insurance coverage and access to care for this large but underserved population. This article discusses the barriers immigrant children face in securing health coverage and quality care and describes

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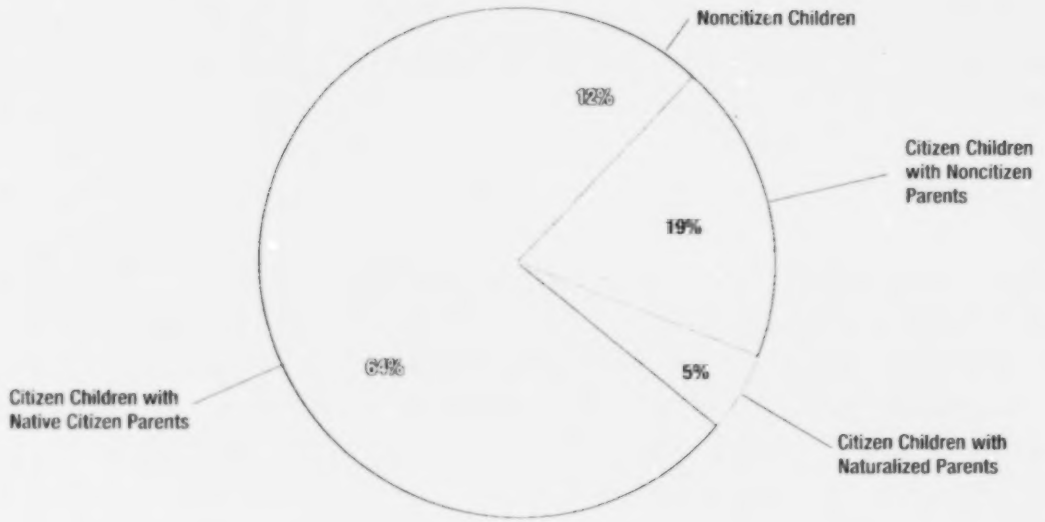
Figure 1

Low-Income, Uninsured Children by Citizenship Status



Source: Center for Budget and Policy Priorities. Current Population Survey, based on an analysis of the 6.7 million uninsured children in families with incomes below 200% of the FPL in the year 2000, March 2001.

strategies that have been adopted to overcome these barriers. The article concludes with policy recommendations and suggestions for future steps to improve public health insurance programs for immigrant children.

Children in Immigrant Families—A Diverse Population with Shared Concerns

Speaking of "children in immigrant families" as a homogeneous group is misleading because these children are extremely diverse. Immigrant families come from every country in the world, speak a multitude of languages, and bring a host of cultural traditions to their new homeland. Most children in immigrant families are U.S.-born and therefore are native citizens whose parents are immigrants, but many other children are foreign-born noncitizens. Despite this diversity, immigrant families have shared challenges and concerns. This section details some of the most common barriers that impede immigrant families' access to health coverage, including federal eligibility rules and fear of jeopardizing immigration status. The section also describes communication barriers that can influence the quality and cost of health care that immigrant families receive, as well as their use of health services and satisfaction levels with their health care.

Barriers to Securing Health Insurance Coverage

Regardless of immigration status, children from low-income families often lack adequate health insurance. But immigrant children are uninsured in even greater numbers than their low-income peers in citizen families,[4] a disparity that has increased over time. For example, in 2000, about one-half of low-income noncitizen children and more than one-quarter of low-income citizen children with noncitizen parents were uninsured

(see Figure 2). In comparison, one-sixth of low-income children from citizen families lacked coverage.[5] Moreover, the share of low-income noncitizen children who were uninsured increased by seven percentage points from 1995 to 2000, while the share of low-income citizen children who were uninsured fell by 2% during the same period (see Figure 3).

One key factor that affects these children's health coverage is the economic and employment status of their immigrant parents. A disproportionate share of immigrant parents hold low-wage, poor-quality jobs that do not offer employer-sponsored insurance coverage, so their families lack access to private insurance coverage.[6] Other factors, discussed below, also contribute to their weak insurance coverage, including federal eligibility rules, fears of jeopardizing immigration status, and language and cultural barriers.

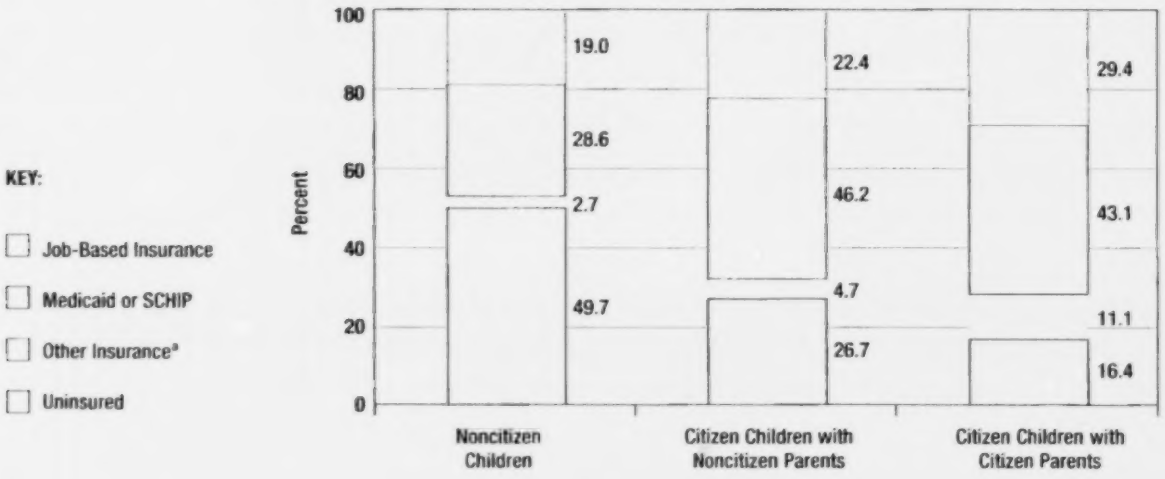
Federal Eligibility Rules

Medicaid and SCHIP are not available to many immigrant children because of eligibility restrictions imposed by the 1996 welfare reform law. Immigrant families have varied immigration statuses that confer different legal rights and affect the extent to which these families are eligible for public programs such as SCHIP and Medicaid (see Table 1). Moreover, the immigration status of children in the same family may differ. As a result, a foreign-born child may be ineligible for insurance coverage, while his or her younger, U.S.-born sibling is eligible as a native citizen.

As Figure 3 shows, the share of noncitizen children covered by Medicaid, and later SCHIP, dropped by nearly eight percentage points from 1995 to 2000. Other studies have found that citizen children in immigrant families also lost Medicaid coverage after the

Figure 2

Insurance Status of Children in Families with Incomes Below 200% of the Federal Poverty Level, by Citizenship Status, 2000



[a]Includes other private and public insurance such as private nongroup insurance or Medicare.

Source: Center for Budget and Policy Priorities. Current Population Survey, based on "verified" insurance data from March 2001.

Table 1

Simplified Guide to Immigration Status and Federal Eligibility for Medicaid and SCHIP

Immigration Status	Definition	Program Eligibility Status
Native citizen	Born in the United States	Eligible
Naturalized citizen	Foreign-born, but became a U.S. citizen through naturalization	Eligible
Lawful permanent resident	Noncitizen with permission to live and work permanently in the United States; has a "green card"	Under 1996 welfare law, those admitted after August 22, 1996, are ineligible during their first five years in the United States, but may receive emergency medical treatment during this period. Other immigrant-specific eligibility rules may pertain even after the five-year period expires.
Refugee/asylee	Admitted to the United States because of fear of persecution in the home country	Eligible for at least first seven years in the United States, under 1996 welfare law
Undocumented alien	Either entered the United States without permission or violated the terms of his or her visa	Not eligible, but may receive emergency medical care
Other lawfully present immigrants	Includes foreign-born people with temporary visas (for example, students, work visas, tourists), persons granted temporary protected status, applicants for asylum, and others with pending immigration status	Not eligible, but some may receive emergency medical care

Source: National Immigration Law Center. *Guide to immigrant eligibility for federal programs*, 4th ed. Los Angeles, CA: NILC, 2002.

1996 welfare law was passed.[7-9] The decline in approved applications for immigrant families is primarily attributable to a decline in application submissions. Considering the substantial changes in welfare regulations and requirements, immigrant families may not have applied because they were unclear about their eligibility status or were fearful that they would be reported to the Immigration and Naturalization Service (INS).[10]

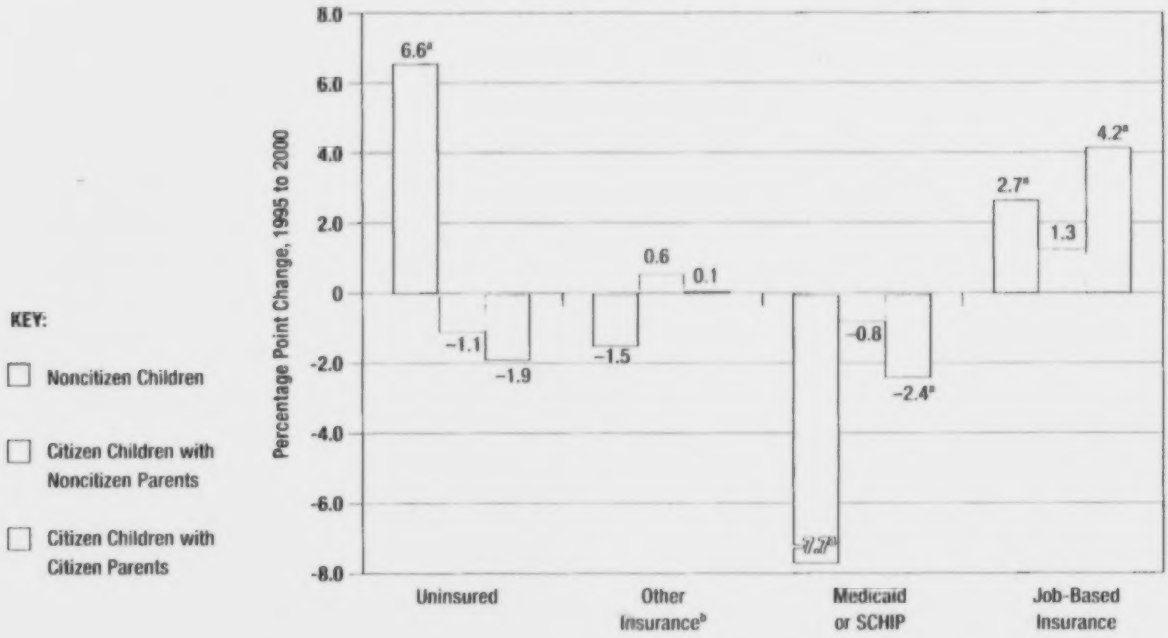
Although qualified immigrants become eligible to receive federal benefits after five years of U.S. residency, other rules interfere with their access to benefits, including health insurance. For example, people who immigrated through family "sponsors"[11] may have their sponsors' income counted in determining eligibility. This "sponsor deeming" rule applies even if the sponsor lives in a separate household and does not actually contribute to the immigrant's financial support. Sponsor deeming will likely make a majority of low-income immigrants ineligible for benefits, even after five years have passed.[12] Moreover, if an immigrant uses certain benefits, including Medicaid and SCHIP, his or her sponsor can be required to repay the government for the value of the benefits used until the immigrant becomes a citizen or has had approximately 10 years employment in the United States. Together, these requirements impose tough barriers to securing health coverage, even when immigrant children are eligible.

In 1998, as states began to implement SCHIP, they began efforts to identify and enroll low-income, uninsured children. At the same time, this effort brought to light the paradoxes regarding the insurance coverage of immigrant children. While the 1996 welfare law made recent immigrant children ineligible, data about insurance coverage of children showed that a large share of uninsured children—about one-third—lived in immigrant families. To reach citizen children in immigrant families, state and local organizations developed initiatives to reach immigrant families, such as conducting outreach in multiple languages and engaging trusted community organizations to help identify and enroll these children. As seen in Figure 3, Medicaid or SCHIP participation of citizen children in noncitizen families recovered somewhat by 2000, suggesting at least partial success of ethnically oriented outreach efforts.

Despite these efforts, citizen children in immigrant families remain much more likely to be uninsured than children in native-born families. Children with one or more undocumented family members appear to have the highest levels of poverty and uninsurance.[13,14] Undocumented persons are ineligible for Medicaid and SCHIP, except for emergency Medicaid services. Because undocumented persons cannot work legally,

Figure 3

Changes in Insurance Coverage of Children in Families with Incomes Below 200% of the Federal Poverty Level, by Citizenship Status, 1995–2000



[a]Change from 1995 to 2000 is significant with a 90% or better confidence level.
[b]Includes private nongroup insurance and Medicare.

Source: Center for Budget and Policy Priorities. Current Population Survey, based on "pre-verified" percentage point changes data because "verified" data are not available for 1995, March 2001.

Given the cultural and linguistic diversity of immigrant families, many encounter problems securing health coverage because of language barriers.

they are subject to exploitation in the labor market and encounter special difficulties securing private health insurance for their families.[15]

Fear of Jeopardizing Immigration Status

Even when eligible for public health insurance coverage, immigrant families often do not enroll, because they fear that receiving benefits might jeopardize family members' immigration status. For example, U.S.-born children of undocumented immigrants are qualified to receive Medicaid or SCHIP, but their parents may be reluctant to enroll them because of fear of exposing their own status. Moreover, in the mid-1990s, immigration and consular officials began to scrutinize immigrants' use of health care benefits. Immigrants learned that their use of health benefits categorized them as "public charges" (an immigration term for people who depend on public aid), jeopardizing their residency. People deemed public charges can be denied entry to the United States, denied reentry after travel abroad, or refused lawful permanent residency. Some officials told immigrants that to remain in or reenter the United States, they would have to repay Medicaid benefits that they or their children had legitimately received.[16]

In light of public health concerns raised by health care providers, state and county governments, advocates, and the immigrant community, the INS clarified that the use of health care programs such as Medicaid and SCHIP (other than long-term care) should not be considered in public charge determinations.[17] Yet a survey conducted in 2000 found that about three-quarters of low-income immigrants continue to believe that there may be some negative repercussions—for example, inability to get a green card or become a citizen—if they or their children receive public benefits such as Medicaid or food stamps.[18]

Language and Cultural Barriers

Given the cultural and linguistic diversity of immigrant families, many encounter problems securing health coverage because of language barriers.[19] A recent study of low-income Latino immigrants and their children suggests that a lack of English proficiency is an important risk factor for being uninsured.[20] The study found that low-income noncitizen immigrants who primarily spoke Spanish were less likely to have insurance coverage for their children or themselves than similar noncitizen immigrants who spoke English. An immigrant with limited English proficiency may have poorer access to insurance for diverse reasons: He or she might not understand outreach messages, be aware of public insurance programs, or be able to complete an application for Medicaid or SCHIP, and might have difficulty getting a high-quality job that offers health benefits. In addition, those with limited English have often been in the United States for a shorter time, are less acculturated, and have poorer educational backgrounds than those with stronger English skills.

Finally, the need to secure insurance to help defray the high costs of medical care may simply be an unfamiliar concept to some immigrants, especially those from countries with universal health care and state-run health care systems. Nonetheless, cultural preferences for health insurance probably do not differ greatly. For example, when employers offer insurance to noncitizen Latino workers, about 80% accept the insurance, a rate similar to that of white and Latino citizen workers.[21] The study suggests that immigrants, like citizens, want health insurance; they simply face more barriers to obtaining coverage.

Barriers to Accessing Quality Health Care

The challenge of improving health outcomes for children in immigrant families is affected not only by difficulties in securing health insurance coverage, but also by the limited access these children have to quality health care. Children in immigrant families have less access to health care than similar children in citizen families, and they may receive less-satisfactory health care services.[22–24] More than one-eighth of low-income, U.S.-born children with noncitizen parents and more than one-quarter of low-income noncitizen children do not have a "medical home"— that is, a

usual place to get health care. As shown in Figure 4, these rates are two to four times higher than those for children of citizens with similar income levels.[25] For about one-half of the children of immigrants, a clinic or hospital outpatient department is their usual source of care. Many of these safety net providers are strained by resource limits or are able to offer only limited services.[26] In addition, case studies in high-immigration cities indicate that immigrants often use low-cost or unregulated forms of health care, such as informal or unlicensed health care providers, self-diagnosis, or medications purchased in questionable settings.[27]

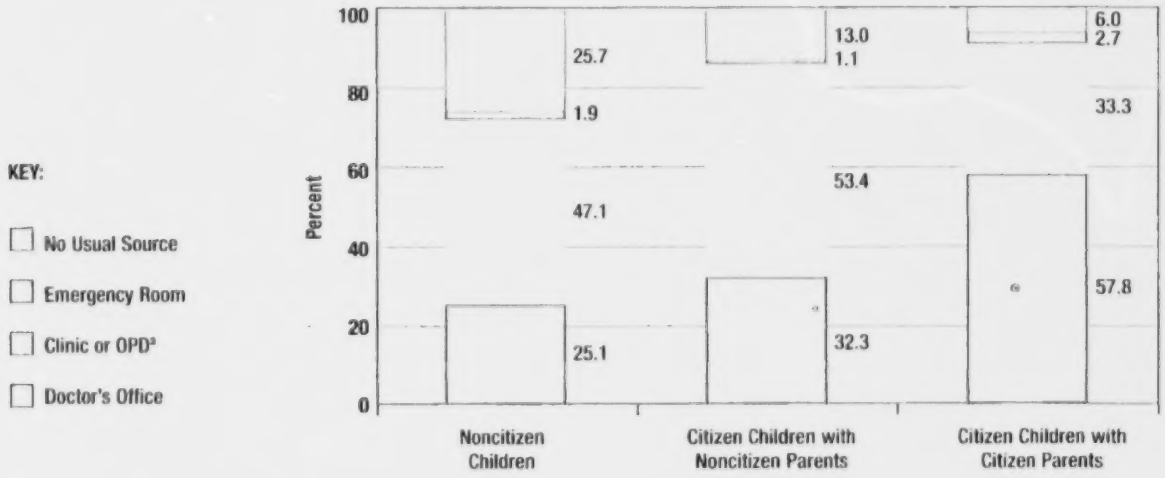
Even after adjusting for race, income, education, health status, and similar factors, children in immigrant families—including both foreign and U.S.-born children—have significantly less access to primary medical or dental care than children in native-born citizen families.[28] Children in immigrant families also use emergency room services less than those in citizen families, contrary to the notion that those with poor access to primary care overuse the emergency room.[29]

The lack of medical homes for children in immigrant families is not surprising given their problems securing insurance coverage. Like most people, children of immigrants have substantially better access to health care services when they have insurance. Nonetheless, data show that even insured children of immigrants have poorer access to health care services than insured children in native citizen families. These data suggest that children of immigrants face other, nonfinancial, barriers to health care.[30]

The most significant nonfinancial barrier appears to be the communication problems that occur when physicians, nurses, receptionists, and other health care staff fail to provide interpreters or other language assistance for patients with limited proficiency in English. As the next section details, language barriers can impede immigrants' access to and use of health care, as well as

Figure 4

Usual Source of Medical Care for Low-Income Children, by Citizenship Status, 1997



*Outpatient department.

Source: Ku, L., and Matani, S. Left out: Immigrants' access to health care and insurance. *Health Affairs* (2001) 20(1):24–56.

the quality of care they receive and their satisfaction with that care. Language barriers may also lead to increased costs.

Language Affects Access and Use

Language barriers can prevent eligible immigrants from applying for programs and visiting health care providers.[31] For example, Latino parents have reported that language barriers are the leading problem they face in obtaining care for their children.[32,33] In one study, one-half of Spanish-speaking Latino parents could not complete Medicaid applications for their children because the forms were not translated, and interpreter assistance was not available.[34] Chinese, Korean, and Vietnamese parents have reported similar problems.[35]

In another study, nearly one-fifth of Spanish-speaking Latinos said they did not seek needed care either because the doctor did not speak Spanish or there was no language interpreter available.[36] One recent analysis found that the probability of having seen a physician during the prior year was substantially higher for low-income children of immigrants who spoke English than for children whose immigrant parents primarily spoke Spanish.[37]

Problems may be even more severe for immigrants who speak less common languages, such as Vietnamese, Chinese, Korean, Haitian Creole, or Russian, for which bilingual health staff or interpreters are harder to find. Similarly, problems may arise when health care providers do not understand their patients' cultures or health beliefs.

Language Affects Quality and Patient Satisfaction

Language barriers also affect the quality of care that immigrants receive and their satisfaction with that care. Spanish-speaking parents have reported that their children have received misdiagnoses, poor medical care, and inappropriate medications because of language problems.[38] In a recent survey, more than one-quarter of patients who needed—but did not get—an interpreter reported that they did not understand instructions about how to take their medications.[39] The same study indicated that these patients were also less likely than those who had interpreters to have been told about financial assistance available for medical bills.

Noncitizen parents who speak Spanish are much less likely than English-speaking immigrant parents to report that their child's physician listened to them and explained things clearly.[40] Not surprisingly, research shows that Spanish-speaking Latinos were much less satisfied with medical care than English-speaking Latinos or English-speaking non-Latinos.[41]

Language May Increase Costs

Communication problems may also increase the cost of care. A study of pediatric emergency room patients found that the average charges for medical tests were significantly higher, and that emergency room stays were longer, when language barriers existed between physicians and patients' families.[42]

In summary, children in immigrant families face major obstacles to securing health coverage and, once they have access, to receiving quality health care. Barriers to access include federal rules that restrict eligibility for public programs, and fears about jeopardizing immigration status by participating in public programs. Once families have access, communication barriers can negatively affect the quality and cost of care that they receive, as well as the frequency with which they use health services for their children.

Strategies for Expanding Access

Recognizing that eliminating barriers to insurance and health care access will improve public health, many states and local communities have developed strategies for covering immigrant children within the boundaries of federal immigrant eligibility restrictions. This section highlights some of the strategies that states, communities, and nonprofit organizations have developed to strengthen insurance coverage and access to care for children in immigrant families.

State-Funded Replacement Programs

States can use their own funds to provide health coverage to children whose immigration status makes them ineligible for federally funded services. As of September 2002, 23 states (including the District of Columbia) provided some form of state-funded, nonemergency health coverage for immigrant children who were not eligible for Medicaid or SCHIP (see Figure 5).[43,44] These state efforts are generally referred to as "state

Figure 5

State-Funded Replacement Programs for Immigrant Children, 2002

[a]Florida serves recent legal immigrant children in its SCHIP program, but caps the number. New Mexico serves children who are permanently residing in the United States under color of law who arrived before August 1996. Wyoming covers legal immigrant children only if they have been abused.

[b]Texas serves recent legal immigrant children in its SCHIP program, but not its Medicaid program. Washington now covers recent legal immigrants under its Basic Health Plan, but not Medicaid or SCHIP.

[c]The District of Columbia serves children with any immigration status, but funding is capped. New York provides care for children with any immigration status in its SCHIP program, but only covers legal immigrant children in Medicaid.

See the text and National Immigration Law Center (2002) for more detail.

Source: National Immigration Law Center, *Guide to immigrant eligibility for federal benefits*, 4th ed. Los Angeles, CA: NILC, 2002.

replacement programs" because they replace some of the benefits the federal government provided to immigrants before the 1996 welfare law. Eligibility rules and benefit packages vary among states. A few states extend coverage to groups ineligible under the pre-1996 rules. For example, the District of Columbia, Massachusetts, New York, and Rhode Island provide at least some coverage for undocumented children.[45]

State Medicaid or SCHIP agencies typically administer state replacement programs. Such centralization provides an opportunity for an agency to use simple, inclusive outreach messages and a coordinated application process to facilitate program enrollment. This approach is particularly helpful for families with children of varying immigration status and program eligibility status.

State replacement programs provide essential medical services to immigrant children barred from Medicaid and SCHIP by federal rules, but the programs are vulnerable to budget cuts in periods of fiscal pressure. During slow economic periods, states' Medicaid expenditures tend to surge while revenues fall, causing many states to contemplate cutbacks in Medicaid programs.[46] Further, unlike regular components of Medic-

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aid, replacement programs draw no federal matching funds, making them more susceptible to budget reductions. Yet, money spent on replacement programs may help states avoid a large portion of the expenses they would otherwise incur in providing emergency Medicaid care to immigrants.[47]

About one-half of the states do not provide replacement programs for immigrant children. In these states, recently immigrated children have access to emergency Medicaid only. Both states and the federal government are required to cover eligible immigrants' emergency medical care under Medicaid. Clinics and charity care provide additional resources in some communities, but these safety net providers are heavily burdened, and many communities lack free or low-cost safety net providers.[48] For example, in California, which has almost 30% of the nation's immigrant population, six counties have no community clinics.

When immigrant families lack full coverage, they may defer care for their children until preventable or easy-to-treat conditions progress, requiring more intensive and costly interventions.[49] This practice may lead to worse outcomes for a child and strain an already burdened emergency services network.[50]

Local Coverage Initiatives

Some communities have developed their own local initiatives to provide health coverage to uninsured immigrant children. The Children's Health Initiative (CHI) in Santa Clara County, California, was one of the earliest local initiatives. CHI provides universal health coverage for all children ineligible for Medicaid and SCHIP, up to 300% of the FPL, regardless of immigration status. Outreach and enrollment for CHI are combined with outreach and enrollment for Medicaid and SCHIP, and the program uses the SCHIP provider network. The program is supported by an innovative combination of public and philanthropic funds. (See the article by Wong in this journal issue for further discussion of the Santa Clara initiative.)[51]

Culturally Competent Outreach and Enrollment

As discussed previously, eligibility for health coverage does not always lead to the enrollment of immigrant children in available programs. Culturally appropriate, community-based outreach is essential to ensuring immigrant children's participation in health insurance programs.

The complexity of immigration eligibility rules invites misinterpretation. Outreach in immigrant communities often involves addressing concerns or correcting misinformation that may have come from trusted sources like relatives or perceived experts. Many immigrant communities are besieged by unlicensed purveyors of immigration assistance, whose understanding of the law can be out of date or simply wrong.[52] Outreach workers in immigrant communities need training to understand families' concerns, time to develop relationships of trust, and technical support from immigrant rights and legal services organizations to accurately interpret eligibility rules.

Working with trusted community-based organizations (CBOs) is an effective way to identify and enroll uninsured immigrant children. Many CBOs concentrate on issues other than health care access, however, and most must stretch scarce resources across a range of community needs. Partnerships that bring together the resources of health groups and the expertise of culturally competent CBOs can further immigrant children's enrollment. One example of such a partnership is the collaboration between the Illinois Coalition for Immigrant and Refugee Rights and the state's Department

of Human Services. The two organizations work together to improve CBOs' capacity to promote immigrant access to public health coverage and other services. The coalition receives funds from the state to provide technical assistance to CBOs and to train CBOs on outreach strategies, case counseling, and language assistance.[53] This partnership has resulted in more uninsured immigrant families applying for and using health services for which they are eligible.

Some communities have a tradition of health-related outreach that naturally supports health coverage enrollment efforts. For example, many Latino communities are served by community health outreach workers called *promotoras*.[54] Promotoras are typically immigrant community volunteers who provide health education and outreach in homes and at farm labor camps. Their roots in the community enhance their outreach efforts and enable them to promote retention in health coverage by helping enrolled families navigate the system.

Addressing Language Barriers

To improve immigrant children's access to coverage and quality care, language barriers must be addressed. To deal with language barriers, outreach workers and organizations promoting access to health care can include education about the availability of language assistance as part of their efforts. Federal policy, under Title VI of the Civil Rights Act, requires providers who receive federal funds (including Medicaid and SCHIP funds) to ensure that people with limited English proficiency have meaningful access to services.[55] Some state laws, regulations, and managed care contracts also require language assistance.[56]

Unfortunately, these requirements are often not met. The cost of providing adequate interpretation services for clients who speak a multitude of languages may dissuade providers from offering such assistance. In some cases, providers may not even be aware of their obligations; or when providers are aware, immigrant families may not be. Agency enforcement efforts rely on complaints, and families with limited English proficiency may be unaware of their rights or afraid to assert them. More aggressive enforcement efforts by responsible agencies would increase the focus on the requirement to provide services. The federal Interagency Working Group on Limited English Proficiency has recently established a Web site that includes multi-language resources that community organizations can use to improve their language-assistance services.[57]

One strategy for improving language services is to develop qualified bilingual staff. Some health care providers have formed pools of bilingual staff, who interpret as needed in addition to their regular duties. For example, Asian Health Services, a community-based clinic in Oakland, California, trains staff and bilingual community members in the skills necessary to become bilingual clinic service providers.[58]

Another strategy is to engage professional interpreters, but they are often in short supply. Some CBOs have responded to this shortage by training community members to become qualified medical interpreters. For example, in Tennessee, Latino Memphis Conexcion collaborated with two county health departments and other CBOs to train Spanish-language interpreters and place them in health care settings throughout the city.[59] Making interpreters available at the community level can help provide services in more languages and at a lower cost than can placing interpreters with individual providers. Such efforts also create employment and professional development opportunities for community members.

Extending Access to Undocumented Children

Even if Medicaid and SCHIP coverage were extended to immigrants who were eligible for public benefits before welfare reform, access to health care would improve only for lawfully present immigrant children. Children who are undocumented would not be helped.

Streamlining enrollment for emergency Medicaid coverage is one option already permitted under federal law for covering undocumented children. When children's immigration status makes them ineligible for "full scope" Medicaid, states typically enroll them into emergency Medicaid on an ad hoc basis after an emergency occurs. States are also permitted to enroll undocumented children in Medicaid in the same manner as other beneficiaries, but restrict their benefits to emergency services. One study found that California, which enrolls undocumented immigrants in advance, covers far more immigrants at a much lower per capita

cost than states enrolling immigrants after emergencies.[60] While this approach would not provide access to the full range of preventive, primary, and rehabilitative services, it could nonetheless enhance access to emergency care and promote earlier and less costly interventions when emergencies arise.

Some communities have implemented local initiatives aimed at ensuring health coverage for all low-income children, including immigrants, and a few states have opted to use their own funds to insure children regardless of immigration status (see Figure 5). In addition to providing needed care and protecting the public health, these local initiatives have increased eligible children's enrollment in Medicaid and SCHIP. The federal government could follow their example and extend full Medicaid and SCHIP coverage to income-eligible children, without regard to their immigration status. While such an extension of health insurance coverage presently seems politically unlikely, the country has recognized the benefits of providing a healthy start to all children in certain other programs. For example, undocumented children are currently eligible for nutrition programs such as school lunch and breakfast.

Another key strategy for helping undocumented children is to provide adequate financial support to safety net health care providers who offer free and subsidized care regardless of immigration status. These facilities provide a major share of care for low-income, uninsured immigrant families.[61,62]

A final option, with wider implications, is to assist undocumented families in becoming legalized, either with legal assistance or through broader legislative efforts. At any given time, almost 20% of those counted as undocumented are either family members caught in INS backlogs or people applying for asylum. Others have characteristics that may make them eligible for an adjustment of their status, but they lack the legal advice needed to navigate the system and obtain the adjustment. In addition, Congress has considered proposals for legalizing certain groups of undocumented people, such as students. Even if persons legalized under such an effort were excluded from benefits like Medicaid or SCHIP, legalization could help families get better jobs and thereby improve their chances of securing private health insurance.

Conclusion

Children of immigrants represent a growing share of all American children, and their families are increasingly dispersed across the United States. Protecting and preserving the public health requires policymakers to confront the challenge of providing access to health care for these families.

Adequate health insurance coverage is a critical first step to accessible, quality health care; yet obtaining this coverage is far more burdensome for children in immigrant families than for their native-born peers. Immigrant families face difficulties in securing job-based insurance, and their eligibility for public health coverage is limited. Immigration concerns and language barriers inhibit enrollment in programs for which families are eligible, and a lack of culturally and linguistically appropriate services further limits access to quality care. Major efforts are needed to increase the number of immigrant children with access to quality health care. Three elements are key: restoring and expanding federal eligibility rules for Medicaid and SCHIP; working with trusted community groups; and improving linguistic and cultural competence.

Restoring Eligibility

A primary focus must be restoring the federal eligibility for public health coverage for lawfully present immigrants that was curtailed by the 1996 federal welfare law. In addition to aiding the large number of low-income immigrant children who are now barred, restoring immigrant eligibility could help states simplify their application processes for all children. Currently, families must be told that some lawfully present children are eligible, while others are not. Establishing equitable eligibility rules for immigrant and citizen children would improve and simplify outreach efforts by sending a clearer message to families.[63,64]

Regardless of whether or not federal legislation is amended to restore immigrants' eligibility for Medicaid and SCHIP, more states could take the initiative to fund state replacement programs to serve this needy population. The costs of providing preventive health care for children are modest and should be viewed as an incremental expense, since states already must cover emergency benefits for recent immigrant children.

Working with Community Groups

Restoring immigrants' eligibility will not, by itself, guarantee enrollment or access to health care services. Recent experiences in SCHIP outreach and enrollment initiatives point to the importance of collaboration with trusted community groups who can explain the significance of health insurance coverage and help allay fears that getting medical assistance might endanger a family's immigration status. Health care providers, state and local governments, and advocates have begun to document the existence and effects of barriers that limit access to health care, paving the way for helpful federal agency guidance and congressional restorations.

Improving Linguistic and Cultural Competence

Immigrant parents and their children need access to linguistically and culturally competent health care providers, as well as assistance in applying for health benefits and using the health care system.[65] Although health care providers, managed care organizations, and insurers have begun to recognize that linguistic and cultural competence are integral to quality care, little is known about the most effective methods of ensuring meaningful access. In policy, practice, and research, more needs to be done to understand and reduce the disparities in access to quality health care services that affect the children of immigrants in the United States.

Government agencies, advocates, and community groups need to coordinate and collaborate in their efforts to craft policies that respond to the complexity of immigrant families' needs and to eliminate the remaining barriers to providing adequate, accessible, and quality care for this significant proportion of children in the United States.

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5. These data are based on analyses of the March 2001 Current Population Survey (CPS), produced by the Center on Budget and Policy Priorities. Noncitizens include both legal and undocumented immigrants; the CPS does not differentiate these categories. Urban Institute analysts have imputed immigration status to the CPS data and estimate that more than one half of the uninsured noncitizen children are undocumented (see the article by Holahan, Dubay, and Kenney in this journal issue). We note, however, that the imputation process is complex and impossible to verify; it may inadvertently introduce a substantial measure of imputation error. Analysts should be cautious about the interpretation of these data, with or without imputations.
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44. There is considerable variation among the state replacement programs shown on the chart. States shown as providing limited coverage do not extend health coverage to all categories of immigrants who lost eligibility under the 1996 welfare law. These include states, such as Florida, that cap enrollment for replacement programs, as well as states, such as New Mexico, Oklahoma, and Wyoming, that cover only a subset of immigrants who lost coverage, such as victims of domestic violence. Some states limit the services available through their replacement programs. Massachusetts, for example, provides only preventive and primary care to immigrants without qualified status. For more information on state replacement programs, see note 43, National Immigration Law Center. Additional information about state and local health programs is available in Zimmermann, W., and Tumlin, K. *Patchwork policies: State assistance for immigrants under welfare reform.* Washington, DC: Urban Institute, May 1999.

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56. For example, California's Dymally-Alatorre Bilingual Services Act requires bilingual staffing and services at all state agencies where 5% or more customers speak a language other than English. The act notes that "the effective maintenance and development of a free and democratic society depends on the right and ability of its citizens to communicate with their government and the right and ability of the government to communicate with them." California Government Code § 7291. San Francisco and Oakland, California, have enacted local ordinances that require key city departments to hire bilingual staff in public contact positions and to translate vital documents into the major languages spoken by residents with limited English proficiency. San Francisco Administrative Code, chapter 89; Oakland Municipal Code, chapter 2.30. See Perkins, J. *Ensuring linguistic access in health care settings: Legal rights and responsibilities.* Los Angeles, CA: National Health Law Program, January 1998.

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63. Lawfully present children who are ineligible for benefits include qualified immigrant children who arrived in the United States after August 22, 1996, and are subject to the five year bar. See note 43, National Immigration Law Center.

64. Many members of Congress in both parties have expressed their recognition of this fact through their support for the Immigrant Children's Health Improvement Act (ICHIA), which would restore Medicaid and SCHIP eligibility for lawfully present children and pregnant women, currently subject to a five year ban on coverage. The provisions of this bill were included in the Senate Finance Committee's version of the bill to reauthorize the Temporary Assistance to Needy Families (TANF) program in 2002. See National Immigration Law Center. Senate Finance Committee votes to include restoration of immigrant benefits in TANF bill. *Immigrants Rights Update.* July 15, 2002. Available at http://www.nilc.org/immspbs/TANF/TANF004.htm. When this article was revised in October 2002, it was not clear whether or not Congress would include the ICHIA provision in the 2002 version of a TANF reauthorization bill, or even if Congress would pass any reauthorization bill. As of February 2003, Congress has not approved ICHIA.

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The Unique Health Care Needs of Adolescents

Claire D. Brindis, Madlyn C. Morreale, and Abigail English

Health insurance coverage plays a key role in meeting adolescents' needs by increasing their access to health care, yet adolescents are more likely to lack coverage than younger children.[1] One in seven adolescents ages 10 to 18 has no form of public or private insurance.[2] Even higher rates of uninsurance are found among low-income, black, and Hispanic adolescents. For low-income adolescents, insurance through public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) is particularly important. Like younger children without coverage, adolescents without insurance use fewer health services, receive care less frequently, return for fewer follow-up appointments, and are more likely to seek care in an emergency room.[3,4]

While most adolescents are healthy by traditional medical standards, a significant number of young people experience some serious physical or mental health problems or concerns. For example, approximately one in five adolescents suffers from at least one serious health problem, such as chronic conditions, asthma, or depression; and about one in four is believed to be at risk for early unprotected sexual intercourse or substance abuse.[5] Moreover, many health problems occur disproportionately among adolescents who are Medicaid and SCHIP eligible. Low-income adolescents, especially those of color, have higher rates of death, illness, and health risk behaviors in almost every category studied.[6] In addition, other subgroups of adolescents face special, heightened health risks and are more likely to have acute and complex health care needs. These groups include youth who have chronic physical or mental health conditions; live in foster or group homes; are homeless or have run away from home; are undocumented, migrant, or new immigrants; have limited English language skills; are incarcerated or involved in the juvenile justice system; or are pregnant or parenting.[7]

Making adolescent health a priority is especially timely because significant demographic changes are occurring in the United States. While adolescents will represent a smaller proportion of the overall population, the number of adolescents ages 10 through 19 is expected to grow from 39.8 million in 2000 to 42.3 million in 2020, a 6.4% increase.[8] Moreover, adolescent population projections anticipate far greater numbers of young people of color, who are more likely to live in poverty, be uninsured, and underutilize primary and preventive health care services.[9]

This article describes the particular health care needs of adolescents and explores the extent to which public

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health insurance programs are meeting those needs. It includes an overview of the coverage available to adolescents through Medicaid and SCHIP, how that coverage has evolved, the importance of providing comprehensive benefits to adolescents, and the need to adopt age-appropriate quality and performance measures to track progress over time. Throughout the article, recommendations are provided to strengthen health care services for adolescents, informed by the work of several national health care and policy organizations.[10]

Special Health Care Needs of Adolescents

Adolescence is a unique developmental stage of accelerated growth, when a number of physiological, cognitive, social, and emotional changes occur simultaneously. Despite the lack of a formally established age range to define this developmental period, health professionals generally consider adolescence to include young people ages 10 through 19, or those ages 10 through 24.[11] During the transition from childhood into adolescence and again from adolescence into adulthood, youth have complex and important health care needs. Also, adolescence is a critical time to avoid the onset of health-damaging, risky behaviors such as smoking and unsafe sexual activity that can lead to lifelong health problems. Thus, health care services for adolescents need to emphasize prevention, early intervention, and education.

Risk-Taking Behavior

Seven categories of risk-taking behavior account for 70% of adolescent illness, injury, and death: drug and alcohol abuse; unsafe sexual activity; violence; injury-related behavior; tobacco use; inadequate physical activity; and poor dietary habits.[12] Many of these same health-damaging behaviors are related to the majority of adult death and illness.[13] Furthermore, adolescents' perception and assessment of risk seem to differ from adults'. For example, studies suggest that while teens understand the risks involved with engaging in certain behaviors such as smoking, they believe that negative consequences associated with those risks are more likely to affect other people than themselves.[14]

Overall, there is a lack of consensus about the factors underlying adolescents' risk-taking behaviors. Nevertheless, to reduce the prevalence of such behaviors, a range of responses—including preventive health services, legislative and regulatory initiatives (such as those meant to reduce access to cigarettes), and other strategies—likely will be needed.[15]

Preventive and Primary Care

Prevention and primary care services are particularly critical for adolescents because many of the most serious, costly, and widespread adolescent health problems—including unintended pregnancy, sexually transmitted infections, and substance use—are potentially preventable.[16] Early intervention and preventive care could improve adolescents' physical and mental health and reduce death and illness.[17] Through education, screening, anticipatory guidance, counseling, early intervention, and treatment, preventive care can help establish healthy habits that last a lifetime.[18] However, insurance coverage of these services has been uneven and limited. Many adolescents, both those covered in Medicaid and SCHIP as well as those with private insurance coverage, do not receive necessary and appropriate preventive care.[19]

Medicaid and SCHIP both offer a basis for providing low-income adolescents with some essential preventive services, such as regular comprehensive health assessments. For low-income adolescents who are entitled to receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services through Medicaid, many prevention components are included as required elements of a screening visit, and many SCHIP programs also include well-adolescent visits as a benefit. To increase the likelihood that adolescents will actually receive these benefits, purchasers could track them using the Health Plan Employer Data and Information Set (HEDIS)[20] or other quality-measurement tools.

Improving Access to Publicly Subsidized Health Insurance for Adolescents

Medicaid and SCHIP represent the two most significant sources of publicly funded health insurance for low-income children and adolescents. Several researchers and organizations have examined the unique challenges of and opportunities for serving adolescents in Medicaid and SCHIP.[21–24] These studies have found that Medicaid and SCHIP offer the potential to provide comprehensive health insurance coverage to millions of adolescents, and that states have made progress toward covering adoles-

cents in recent years. Nevertheless, the extent to which states implement these programs so that eligible adolescents fully benefit has yet to be determined, and several challenges to serving this population remain.

Adolescents' Eligibility

Historically, adolescents were less likely than younger children to be eligible for public coverage under Medicaid, but program expansions adopted in the late 1980s and early 1990s and the creation of SCHIP in 1997 significantly increased adolescents' eligibility for public coverage.[25]

Medicaid is jointly financed and administered by states and the federal government. States may vary program guidelines as long as they adhere to federal standards or receive federal permission (in the form of a waiver) to depart from those standards.[26] Thus, adolescents' eligibility for Medicaid—along with benefits, provider reimbursement, and many other issues of critical importance to youth and their families—varies by state.

Federal Medicaid law specifies a number of groups that must be covered in every state (referred to as "mandatory eligibility categories") and groups that may be covered if the state chooses to do so (referred to as "optional eligibility categories").[27,28] Before 1988, Medicaid eligibility for children and adolescents essentially was limited to those who qualified on a "categorical" basis, such as those whose parents received cash assistance, Supplemental Security Income for disabilities, or federal foster care or adoption assistance.

Between 1988 and 1990, Congress enacted several laws that required states to expand coverage to children and adolescents based on family income.[29,30] Among these, the Omnibus Budget Reconciliation Act of 1990 was most important for adolescents. It required states to gradually phase in Medicaid coverage (one year at a time) for poor children and adolescents ages 6 through 18, so that by October 1, 2002, all poor adolescents under age 19 would be eligible.[31]

Beyond the mandatory phase-in of coverage for poor adolescents, two optional Medicaid expansions of the 1990s were of particular importance: an option that allows states to provide Medicaid eligibility to age 21 for young people who "age out" of the foster care system after their eighteenth birthdays;[32] and an option that allows states to disregard certain income and assets and to provide coverage for children and adolescents beyond the age or income levels set as minimums under federal law.[33]

Despite these expansions, progress across the states has varied, and Medicaid still serves significantly more infants and younger children than adolescents. During Fiscal Year 1999, the latest year for which data are available, Medicaid served more than twice as many children under age 6 and children and adolescents ages 6 through 14 as it served older adolescents ages 15 through 20.[34] (See Figure 1.)

The creation of SCHIP in 1997 expanded the potential for states to provide public health insurance coverage to adolescents in two significant ways. First, the population eligible for SCHIP (called "targeted low-income children") includes children and adolescents under age 19 in families with incomes less than or equal to 200% of the federal poverty level (FPL) in most states.[35] In addition, the definition of "targeted low-income children" excludes children and adolescents who are eligible for Medicaid, based on eligibility standards in effect on March 31, 1997, and those who do not have access to other insurance.[36] This definition particularly benefited adolescents because they were both less likely than younger children to have been eligible for Medicaid before SCHIP and less likely to have private insurance coverage. By September 30, 2001, only five states did not provide Medicaid coverage to all poor adolescents under age 19: Colorado, Montana, Nevada, Pennsylvania, and Utah did not accelerate the mandatory Medicaid phase-in schedule to cover poor adolescents to a higher age than federal law requires.

Second, because the federal match for SCHIP is more generous than the match for Medicaid, Congress essentially provided states with a financial incentive to use SCHIP funds to accelerate the phase-in of Medicaid eligibility for poor adolescents.[37] As a result, while only 14 states provided Medicaid coverage to all poor adolescents under age 19 as of March 31, 1997, by September 30, 2001, 46 states (including the District of Columbia) provided Medicaid or SCHIP coverage to all poor adolescents under age 19.[38]

When looking at the highest income level at which adolescents are eligible for public insurance (either SCHIP or Medicaid), states' progress is similarly impressive (see Figure 2). On March 31, 1997, only 6 states provided Medicaid coverage to all adolescents under age 19 in families with incomes above 100% of the FPL.[39] By September 30, 2001, all but 12 states provided SCHIP or Medicaid eligibility to all children and adolescents under age 19 with family incomes up to at least 200% of the FPL.[40]

Figure 1

Children and Adolescents Served by Medicaid, Fiscal Year 1999

Source: Based on data from Centers for Medicare and Medicaid Services. *Table 2. Medicaid eligibles—Fiscal Year 1999, by age group, all states.* Available online at http://www.cms.gov/medicaid/msis/99total.pdf.

Progress in Expanding Coverage

During Fiscal Year 2001, nearly 4.5 million children and adolescents under age 19 were enrolled in SCHIP, and nearly one-third (32%) of these enrollees were between ages 13 and 18.[41] An interesting picture emerges when SCHIP enrollment data are analyzed by both age group and program type. First, older adolescents were more likely than younger children to have been enrolled in Medicaid expansion SCHIP—36% of adolescents ages 13 to 18 were enrolled in Medicaid expansion SCHIP, compared with 22% of children and adolescents ages 6 through 12 and 16% of children under age 6.[42] Second,

Figure 2

Medicaid and SCHIP Eligibility for Adolescents under Age 19, Maximum Income Thresholds as of September 30, 2001

Note: In Vermont, 18-year-olds were eligible if family income was up to but not over 225% of the FPL. In Nevada, 18-year-olds were not eligible based on family income alone.

Source: Analysis of approved Medicaid and SCHIP plans and amendments; conversations with state officials.

although more children and adolescents of all ages were enrolled in state-designed SCHIP programs than in Medicaid expansion SCHIP, adolescents ages 13 through 18 represented nearly one-half (46%) of all Medicaid expansion SCHIP enrollees, but only 28% of enrollees in state-designed SCHIP programs during Fiscal Year 2001.[43] (See Figure 3.)

The distinction of enrollment by program type is important because it has implications for the benefits that enrollees may receive, and for whether or not eligibility is an entitlement. For example, because Medicaid is an entitlement program, children and adolescents covered by Medicaid expansion SCHIP will remain eligible for Medicaid even if a state has used up its allotment of SCHIP funds.[44,45] By contrast, there is no entitlement to eligibility in a separate (non-Medicaid) SCHIP program, which means that states can limit services to eligible children and youth by placing them on waiting lists or by capping enrollment.

The proportion of SCHIP enrollees who are adolescents varies considerably by state. During Fiscal Year 2001, for example, adolescents ages 13 through 18 represented anywhere from less than 25% of total SCHIP enrollment (in four states) to 100% of total SCHIP enrollment (in two states). Among the five states that reported a majority of total SCHIP enrollees being ages 13 through 18, four were Medicaid-expansion-only states.[46]

Figure 3

Enrollment in SCHIP by Program Type and Age Group, Fiscal Year 2001

Source: Analysis of data provided by the Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and State Operations, Family and Children's Health Program Group, August 2002. Data based on an unduplicated count of children and adolescents enrolled in SCHIP during Fiscal Year 2001. These figures do not include missing data (not reported to CMS) from Alabama (Medicaid expansion data) and Illinois (all data).

Benefits Available to Adolescents

Once adolescents enroll in Medicaid or SCHIP, their access to particular benefits may vary, depending on the state in which they live and the type of program for which they are eligible. The Medicaid benefit package includes a broad range of mandatory and optional services.[47] However, for children and adolescents under age 21, all mandatory and optional Medicaid services must be made available by a state if medically necessary.[48] Nevertheless, states are allowed to impose initial limits on the amount, duration, and scope of a particular benefit—such as mental health services—and adolescents may have to overcome such limits to obtain all the services they need. Also, states may be less generous to adolescents than to younger children, such as in establishing the frequency of required comprehensive health assessments, or screenings, in Medicaid.

The scope of benefits available in a state's SCHIP program depends on the type of program that was created—that is, Medicaid expansion, combination, or separate SCHIP program (see the article by Wysen, Pernice, and Riley in this journal issue). Benefits for adolescents in Medicaid expansion SCHIP must meet the requirements for Medicaid. Benefits for adolescents in a state-designed SCHIP program must meet minimum criteria, but they can be more generous. Uniform data about the range of services offered to adolescents under state-designed SCHIP programs are not readily available, although some state-by-state data about specific benefits suggest that states vary with respect to preventive health services, reproductive health services, substance-abuse and mental health services, dental services, and the breadth and depth of the benefit package for adolescents with special health care needs.[49]

Improving Health Care for Adolescents through Public Health Insurance Programs

Even though health insurance—whether private or public—plays a critical role in adolescents' access to health care services, it does not guarantee that adolescents will actually receive the services they need to assure their overall health. A number of significant barriers, both financial and nonfinancial, prevent young people from receiving needed care (see Box 1).

To improve adolescent health, states must respond to adolescents' barriers to care and establish systems and provider networks that are available, accessible, and appropriate for this population. To aid states in such efforts, the Society for Adolescent Medicine has compiled a list of criteria for evaluating access to quality care for adolescents (see Box 2).

Insurance coverage is an essential part of access to care, and Medicaid and SCHIP provide states with an

Box 1

Barriers to Health Care for Adolescents

- **Shortage of providers trained in adolescent health.** Few clinicians specialize in adolescent health, and most medical staff are inadequately trained to recognize health problems whose symptoms may be primarily psychosocial instead of physical. Although most adolescent medicine specialists are trained as pediatricians, internists and family physicians reflect the most common pathways to care for adolescents.
- **Inadequate provider reimbursement/low provider participation.** Reimbursement and capitation rates for providers serving children and adolescents are significantly lower for public insurance than for private insurance. In addition, delays in receiving payment from public insurance create a strong disincentive for health care providers to serve publicly insured adolescents.
- **Limited insurance coverage.** Health insurance policies (both public and private) often sharply limit or do not cover visits for preventive care, mental health services, substance-abuse treatment, dental health, and other needed care.
- **Focus on acute, medical care.** The health care system has traditionally emphasized the treatment of physical problems rather than health promotion and disease prevention, including mental health care. Adolescents could benefit significantly from preventive and primary care services that integrate their physical and psychosocial needs, such as screening, education, and anticipatory guidance to prevent and/or ameliorate risk-taking behaviors that place adolescents at risk for poor health.
- **Fragmentation.** Most teenagers and their families find navigating the complex and rapidly changing health care system difficult. Most young people are ill-prepared to understand how to access health services, have limited knowledge regarding their eligibility for diverse programs, and have few skills with which to recognize and anticipate their own needs for health services or to advocate for their own needs.
- **Confidentiality.** Without confidentiality protections, some adolescents will forgo care for such issues as pregnancy, sexually transmitted diseases, or substance abuse. Assurances of confidentiality have been found to increase adolescents' willingness to disclose information, report truthfully, and consider a return visit.
- **Transportation/inconvenient hours.** Most teenagers have to rely on their parents and/or public transportation to reach health care providers, yet few physicians and community health clinics have scheduled their locations or hours of service to accommodate adolescents' needs. Long waits to obtain an appointment and/or long waiting times at the provider site may deter adolescents even more than adults.
- **Cost.** Even very low co-payments may discourage adolescents and their families from initiating preventive or primary care visits. Families with low incomes may also struggle with premiums and deductibles required by employers, state-sponsored/subsidized programs, and/or private insurance policies.

Box 2

The Society for Adolescent Medicine's Criteria of Assessing Adolescent Care

- **Availability:** Age-appropriate services and trained health care providers must be present in every community.
- **Visibility:** Health services for adolescents must be clearly recognizable and convenient and should not require extensive or complex planning by adolescents or their parents.
- **Quality:** Health professionals treating adolescents should demonstrate a basic level of competence with adolescents, who in turn should feel satisfied with the care they receive.
- **Confidentiality:** Adolescents should be encouraged to involve their families in health decisions, but confidentiality must be assured.
- **Affordability:** Public and private health insurance programs must provide adolescents with both preventive and other additional services to decrease morbidity and mortality and to promote positive health behaviors.
- **Flexibility:** Providers, services, and delivery sites must consider the cultural, ethnic, and social diversity among adolescents.
- **Coordination:** Service providers must ensure that comprehensive services are available to adolescents.

Source: Klein, J., Slap, G.B., Elster, A.B., and Schonberg, K.B. Access to health care for adolescents: A position paper for the Society for Adolescent Medicine. *Journal of Adolescent Health* (1992) 13(2):162–70.

unprecedented opportunity to improve health care for adolescents. Yet, much work remains to ensure that adolescents actually enroll in and benefit from public insurance programs. This work includes addressing gaps in eligibility, improving outreach and enrollment, offering a broad range of services, and assuring confidentiality.

Addressing Gaps in Eligibility

Despite recent progress in making more adolescents eligible for public health coverage, gaps in eligibility remain. Some groups of adolescents, including many legal immigrant youth, adolescents who are exiting state custody, and older adolescents, are particularly vulnerable, either because they are not eligible for public health coverage under current federal or state rules or because they are not identified or screened for eligibility.

Coverage for Legal Immigrants

As described in the article by Lessard and Ku in this journal issue, numerous studies have shown that immigrant families have significant health care needs, yet are more likely than others to lack health insurance and face numerous barriers to accessing health services. For example, the 1996 federal welfare law (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) substantially restricted many immigrants' eligibility for public benefits, including Medicaid and later SCHIP.[50] While efforts to address the unique health care needs of immigrant families must include a diverse array of strategies, addressing legal and policy barriers to care and coverage is of critical importance in serving adolescents within this population.

At a minimum, to help ensure coverage for legal immigrant adolescents:

- Congress should enact legislation that permits states to expand eligibility for Medicaid and SCHIP to immigrants who are lawfully present in this country.

Coverage for Adolescents Leaving State Custody

Each year, as many as 20,000 young people age 16 or older leave the foster care system and are expected to live independently.[51,52] Most of these young people lack familial, financial, and other support, and many have seri-

ous unmet physical and mental health needs.[53] Although relatively small in number, this is an unusually vulnerable group of young people in terms of health status, likelihood of having insurance, and access to care.[54] As described previously, the Foster Care Independence Act of 1999 (FCIA) included a new option for states to expand Medicaid coverage to age 21 for young people who were in foster care on their eighteenth birthdays. Unfortunately, by July 2002, only eight states had enacted or implemented this option, although several others had at least considered doing so.

While the new FCIA Medicaid expansion option is critically important, it does have limitations. For example, it does not provide the opportunity to expand coverage to adolescents who leave the foster care system before age 18, even though they, too, may be expected to live independently. In addition, approximately 42,000 adolescents age 16 and older depart the foster care system every year and either reunite with their parents, go to live with other relatives, are transferred to the custody of another agency, or run away.[55] Significant numbers of these adolescents are likely to be eligible for Medicaid or SCHIP on the basis of income, but are not systematically screened for eligibility when they leave the foster care system.[56]

Young people transitioning from the juvenile justice system also have significant health problems and face numerous barriers to obtaining health care. Each year in the United States, hundreds of thousands of youth are held in the custody of the juvenile justice system at the state and local levels.[57] For example, the National Center for Juvenile Justice reported that nearly 106,000 juvenile offenders were held in residential placement facilities during a one-day census count in 1997.[58] These youth included juveniles who were under age 21, had been charged with or adjudicated by a court for committing an offense, and were in residential placement because of that offense. Annual numbers reveal that in 1993, more than 800,000 youth were held in short- and long-term facilities in the United States[59] and that these young people were disproportionately members of racial and ethnic minority groups.[60,61]

The juvenile population is characterized by a wide variety of pressing health problems, including behavioral health

problems and acute and chronic medical conditions.[62,63] In particular, youth in the juvenile justice system experience significant mental health problems.[64] These young people often receive inadequate health care, especially mental health care, in juvenile justice custody,[65-67] and their health problems are likely to persist when they leave state custody. Although while they are incarcerated, many of them cannot receive Medicaid or SCHIP coverage; when they exit state custody, most would be eligible for one of these programs.

To help ensure coverage for vulnerable adolescents leaving state custody:

- States that have not already done so should expand Medicaid eligibility to include young people who exit the foster care system at age 18 or thereafter.
- States should screen all young people exiting the juvenile justice and child welfare systems for Medicaid and SCHIP eligibility.

Coverage Based on Age and Income

Despite the recent expansions of Medicaid and SCHIP coverage, millions of poor and low-income adolescents remain uninsured. Many of these adolescents are already eligible for one of these programs, but simply are not enrolled. Others live in states that have not raised their SCHIP eligibility levels as high as permitted under the federal statute, and others do not qualify because they are in families with incomes that exceed the federal limits, or they are older than age 18.

According to the latest data available from the U.S. Census Bureau, more than 5.7 million children and adolescents under age 19 in families with incomes at or below 200% of the FPL were uninsured during 2001,[68] even though based on family income, virtually all of these individuals could have been eligible for Medicaid or SCHIP. (See the article by Holahan, Dubay, and Kenney in this journal issue.)

Older adolescents, those age 18 through 24, are less likely to have health insurance than those in any other age group. According to the U.S. Census Bureau, 28% of youth age 18 through 24 were uninsured during 2001 (compared with 12% of children and adolescents under age 18, 17% of persons age 25 through 64, and less than 1% of persons age 65 and older).[69] As with other age groups, rates of uninsurance are higher among older adolescents who are poor—nearly one-half (46%) of poor adolescents age 18 through 24 were uninsured during 2001. The 107th Congress considered several bills that would have begun to address the eligibility gaps that remain for older adolescents and those in families with incomes above 200% of the FPL, but did not enact any of these bills before it adjourned.[70]

To help ensure coverage for low-income adolescents:

- States that have not already done so should expand Medicaid and SCHIP to all children and adolescents in families with incomes up to 200% of the FPL, or the highest level permitted (given their pre-SCHIP eligibility rules).
- The federal government should permit states to expand Medicaid and SCHIP eligibility to older adolescents (under age 24) and to children and adolescents in families with incomes above 200% of the FPL.

Outreach and Enrollment

To increase the enrollment of eligible children in public health insurance programs, a wide variety of outreach strategies have been implemented. (See the article by Cohen Ross and Hill in this journal issue.) Little of this activity has specifically targeted adolescents,[71] however. There is a critical need to evaluate which approaches are most likely to reach adolescents generally and which are most likely to reach particular subpopulations of youth who are at increased risk of health problems and access barriers. Meanwhile, a number of outreach and enrollment strategies have been recommended for adolescents.[72] These include:

- Providing outreach and adolescent-oriented written materials at sites frequented by young people, such as school-based health centers, family planning and sexually transmitted infection clinics, adolescent medicine clinics, county health departments, high schools, Job Corps sites, summer job programs, recreation centers and after-school programs, movie theaters, and malls.
- Developing outreach materials and strategies to reach special populations of adolescents, such as runaway and homeless youth, pregnant and parenting adolescents, adolescents in immigrant families, adolescents with spe-

Many adolescents will seek health care services—particularly for such issues as pregnancy, sexually transmitted infections, or substance abuse—only if they can receive services confidentially.

cial health care needs, and adolescents eligible for other publicly funded programs.

- Training adolescents and young adults to conduct outreach and staff speakers' bureaus and teen telephone lines.

- Teaching enrollment brokers, contractors, health care workers, and EPSDT workers and other staff at out-stationed and presumptive eligibility sites about adolescent health and the importance of reaching this population.

To effectively reach and enroll adolescents who are eligible for Medicaid and SCHIP:

- States should work with a broad array of service organizations, agencies, schools, and health care providers to develop, implement, and evaluate outreach and marketing strategies targeted to adolescents (including special populations) and their families.

- Strategies should be designed to provide information to adolescents about accessing health services, including information about finding adolescent-oriented providers, setting up appointments, co-payment requirements, grievance options, and the importance of bringing insurance cards to appointments.

Offering a Broad Range of Services

Adolescents require a broad range of health care services to address their multiple needs. Services of particular importance include preventive services, family planning and reproductive health services, mental health and substance-abuse services, dental care, and services related to chronic illnesses or disabilities.[73] Medicaid and SCHIP both offer opportunities to ensure the provision of these services for adolescents.

Preventive Services

Preventive services represent a key set of benefits in Medicaid and SCHIP, because many common health problems faced by adolescents are preventable. The rapid developmental changes that occur in adolescence necessitate frequent health assessments in order to identify new health issues and risk behaviors early. Medicaid requires states to establish a schedule for comprehensive health assessments in consultation with professional medical and dental organizations involved in child health care,[74] and there is broad consensus among professional groups that annual health assessments for adolescents are needed.[75]

In Medicaid, EPSDT is the cornerstone of preventive care for children and could result in the provision of comprehensive care for adolescents. Yet, full implementation of EPSDT has not been achieved.[76] (See Box 3 for one example of a state's effort to enhance delivery of EPSDT services.) Also, not all states have provided for annual well-adolescent exams in their state-designed SCHIP programs.

To provide for annual well-adolescent visits consistent with the most current recommendations for adolescent care:

- States should update their EPSDT periodicity schedules and ensure that all health plans and providers are using the updated schedules.

- States with separate (non-Medicaid) SCHIP programs should incorporate requirements for annual comprehensive well-adolescent evaluations into their benefit packages.

- States should ensure that their Medicaid and SCHIP programs cover appropriate preventive services for adolescents in accordance with the most current guidelines.

Family Planning and Reproductive Health Services

Among adolescents, high rates of unintended pregnancy and sexually transmitted infection (including HIV) make access to family planning and reproductive health services critical. A broad range of federal programs, including Medicaid and SCHIP, can help states meet adolescents' needs for reproductive health services. In Medicaid and Medicaid expansion SCHIP, family-planning services are a mandatory and confidential benefit. In state-designed SCHIP programs, states may include family-planning services as a benefit. Recent data indicate that although most states have provided coverage for reproductive health services for adolescents in their SCHIP programs, fewer require providing adolescents with information about the full range of reproductive health services or

Box 3

Spotlight on Preventive Health Services—EPSDT in Massachusetts

Massachusetts' Medicaid agency, the Division of Medical Assistance (DMA), has taken a number of steps to improve the delivery of preventive services to Medicaid-eligible adolescents. These steps include:

- Forming a task force of state agency staff, health care providers, representatives of managed care plans, and advocates to identify barriers and develop strategies for improving adolescents' access to care.
- Adopting new Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) regulations and updating the agency's periodicity schedule to specify annual visits for adolescents through age 20.[a] DMA expects adherence to the annual exam requirement in both its managed care and fee-for-service Medicaid programs, and DMA reimburses its Medicaid providers accordingly.
- Providing annual visits for adolescents enrolled in the state-designed component of the state's SCHIP program.
- Publicizing the new requirements to health care providers. For example, the state sent a letter to providers on American Academy of Pediatrics (AAP) letterhead, signed by the chair of the AAP committee that developed the schedule and the chair of the Massachusetts chapter of the AAP. The state put information in the AAP news, the newsletter for community health centers, and its own quarterly letter to primary care providers, and also held trainings on the new schedule.

[a] The EPSDT periodicity schedule is consistent with AAP guidelines, Guidelines for Adolescent Preventive Services (GAPS), and Bright Futures, as well as with the Medicaid HEDIS indicator that calls for annual comprehensive well-adolescent exams. It is also reflected in a set of guidelines endorsed by the Massachusetts Health Quality Partners, a broad group composed of state health agencies including DMA, professional medical societies, hospitals, medical schools, and numerous health plans and insurers.

Sources: *Transmittal letter ALL-99: Appendix W—EPSDT services: Medical protocol and periodicity schedule.* Commonwealth of Massachusetts, Division of Medical Assistance, May 14, 2001; Massachusetts Health Quality Partners. *MHQP Guidelines: Pediatric Preventive Care Recommendations 2001.* Available online at http://www.mhqp.org/PediatricRec.pdf; and 130 Code of Massachusetts Regulations §§ 450.142, 450.145, and 450.150 (LEXIS 2002).

how to access care.[77] In addition, although many laws protect the confidentiality of adolescents (as discussed later), few states report guaranteeing confidentiality.[78]

To ensure adolescents' access to essential family-planning services:

- States should ensure that adolescents enrolled in Medicaid and SCHIP are informed of the family-planning services available to them and how to access them.

Mental Health and Substance-Abuse Services

High rates of suicide, depression, and substance abuse in adolescents[79] suggest that many teens need access to mental health and substance-abuse services. Although Medicaid and SCHIP provide the possibility of broad coverage for mental health and substance-abuse services, numerous limitations exist, such as high cost sharing and restrictions on numbers of outpatient visits per year, numbers of inpatient days permitted, and the types of providers who can deliver services and be reimbursed.[80-83] While these limitations generally also apply to younger children and adults, they are likely to have greater significance for adolescents: During this developmental period, many behaviors and illnesses that require mental health services—such as drug use, depression, and eating disorders—have their onset.

Many adolescents could be helped by receiving preventive mental health services before emotional or behavioral problems become severe. But often, services are not available through Medicaid, SCHIP, or private insurance without a diagnosis. Nevertheless, some states are beginning to adopt innovative approaches to increase adolescents' access to mental health and substance-abuse services,[84] and at least one state, North Carolina, has made a significant effort to address these problems (see Box 4).

To address the mental health and substance-abuse problems of adolescents:

- States should include coverage in their Medicaid and SCHIP programs for a limited number of preventive mental health visits without a diagnosis being required.
- States should include coverage in their Medicaid and SCHIP programs for care coordination to help families and primary care providers integrate medical care, mental health care, substance-abuse treatment, and social services for adolescents.

Dental Care

Dental and oral health problems are particularly severe for adolescents of all races and ethnic groups who live in poverty, compared with higher-income youth.[85] For youth who smoke, tobacco use contributes to significant oral health problems, and adult gum disease may have its onset at this time.[86] Nonetheless, access to dental care for adolescents is particularly limited, with lack of insurance and low family income being major barriers to adolescents' use of preventive dental care.[87]

Medicaid provides dental coverage for children and adolescents, and most non-Medicaid SCHIP programs provide dental coverage, but many limitations exist with respect to scope of coverage and cost sharing.[88] As with younger children, even adolescents with insurance coverage often have difficulty finding providers who accept Medicaid payments, and they encounter long waiting lists.[89]

To help ensure that adolescents receive adequate dental care:

- States should implement comprehensive strategies to increase adolescents' access to dental services in Medicaid and SCHIP.

Box 4

Spotlight on Mental Health Benefits—North Carolina

In 2000, North Carolina expanded access to mental health benefits for children and adolescents covered by its public health insurance programs by improving the coverage of preventive mental health services and broadening the scope of providers who may bill Medicaid for their services.

North Carolina now allows up to six visits to specified mental health and substance-abuse providers without a diagnosis of mental illness. This policy allows adolescents to receive preventive mental health and substance-abuse services without being formally "labeled" or diagnosed with a psychiatric disorder. This policy applies to Health Choice, North Carolina's state-designed non-Medicaid SCHIP program; Health Check, the state's Medicaid program for children; and the state employees benefit program, on which the Health Choice benefit package is based.

In addition, Medicaid policy in North Carolina has been subsequently amended to expand opportunities for a broader range of health care professionals—such as licensed clinical social workers, master's-level psychologists, and nurse practitioners with specialized training—to bill for their services. North Carolina now permits these mental health professionals who are practicing independently to enroll directly as Medicaid providers and to bill for services delivered in their offices.

Like many other states, North Carolina is experiencing severe budgetary crises, including crises in Medicaid and SCHIP. The extent to which these crises will impede implementation of North Carolina's preventive mental health expansion is not yet known.

Sources: Division of Medical Assistance, North Carolina Department of Health and Human Services. *Medicaid Bulletin* (June 2000):13; and Foy, J. North Carolina Pediatric Society task force on mental health care access, mental health task force reports Medicaid changes to help pediatricians serve children. Unpublished information bulletin of the North Carolina Pediatric Society. No date.

Services for Chronic Illness or Disability

Approximately 1.8 million adolescents ages 12 to 17 experience some degree of limitation due to chronic conditions, a prevalence rate that is higher than the rate for younger children.[90] The breadth and depth of the benefit package is particularly critical for adolescents with chronic illnesses or disabilities, who often require services of greater variety, intensity, and duration than do other youth. For example, these adolescents may need physical, occupational, or speech therapy, for which benefit limitations are often imposed.[91] While Medicaid and SCHIP offer the potential to provide comprehensive care to adolescents with special health care needs, services are not always accessible, and important benefits for this population are sometimes limited.[92-94]

Assessing the relative effectiveness of Medicaid and state-designed SCHIP programs in meeting the needs of adolescents with chronic illnesses or disabilities is difficult. State-designed SCHIP programs have greater latitude in shaping their benefit packages, and the effect varies among the programs: Some states have elected to limit the types of benefits important for adolescents with chronic conditions, but some have chosen to offer an enriched benefit package for children and adolescents with special health care needs that is equivalent to the breadth of the Medicaid benefit package.[95] (See the article by Szilagyi in this journal issue for a more complete discussion of children with special health care needs.)

To address the needs of adolescents with chronic illnesses or disabilities:

- States should offer an expanded benefit package in state-designed SCHIP programs for children and adolescents with chronic illnesses or disabilities.

Assuring Confidentiality

Many adolescents will seek health care services—particularly for such issues as pregnancy, sexually transmitted infections, or substance abuse—only if they can receive services confidentially.[96-98] Studies show that assurances of confidentiality increase adolescents' willingness to disclose information, report truthfully, and consider a return visit, and that without confidentiality protection, some adolescents will forgo care.[99,100]

Numerous federal and state laws affect the confidentiality of adolescents' health care information, addressing issues such as when adolescents may give their own consent for care and when information is shared with parents. At the federal level, new medical privacy regulations, initially issued in late 2000, contain specific requirements regarding the confidentiality of medical records and information pertaining to the care of minors, including adolescents who are under age 18.[101] These rules, which went into effect in 2001 and were modified in August 2002,[102] stipulate that when minors can receive health care based on their own consent—that is, without parental consent—they can exercise most of the privacy rights provided under the federal privacy regulations.[103] However, the rules give states greater latitude to determine the extent of privacy protections for minors than for adults and defer to "state or other law" on the question of when otherwise protected information may or must be disclosed to parents. The federal Title X Family Planning Program and the federal confidentiality regulations for drug and alcohol programs also include strong confidentiality protections for adolescents who seek treatment on their own.[104] Finally, both Medicaid and SCHIP include some confidentiality protections that should extend to adolescents receiving services.[105]

At the state level, every state has laws that control the confidentiality of medical information and records[106] and allow minors to give their own consent for health care in specific circumstances.[107] The minor consent laws generally are based either on the status of the adolescent minor or on the services being sought.[108] Overall, every state offers some confidentiality protections to adolescents who are minors (under age 18), while adolescents age 18 or older generally receive the same confidentiality protections as other adults.

To ensure that adolescents who are served in Medicaid and SCHIP are able to access essential services on a confidential basis:

- The federal government and states should ensure that health plans and health care providers adopt medical record, billing, and laboratory procedures that protect the confidentiality of services provided to adolescents.
- States and health plans should provide health care providers and enrollees with specific information about minor consent and confidentiality protections that exist for adolescents.

Quality and Performance Measurement

Policymakers, purchasers, researchers, health care providers, and consumers have become increasingly concerned about the quality of health care provided through both commercial and publicly funded insurance programs.[109] Considerable progress has been made in recent years toward developing and testing quality-measurement strategies and tools related to the care received by children and adolescents. For example, some quality-measurement tools include items of particular importance to adolescents, such as adolescent well-care visits; screening for chlamydia; utilization of mental health services; screening, counseling, and treatment for substance abuse and chemical dependency; immunization status; and counseling for risk behaviors and other issues such as diet, exercise, and emotional health.[110]

Nevertheless, only a small number of states have adopted these measures or items for their Medicaid and SCHIP programs, and little is currently known about how adolescents use services in Medicaid and SCHIP or the quality of services that these programs provide.[111] For example, while every state is collecting quality or performance data related to SCHIP enrollees' use of health care services, few states have established performance goals or strategic objectives for SCHIP that address issues of particular importance to adolescents. Of the 33 states that included performance measures related to immunization status in their Fiscal Year 2001 annual reports for SCHIP, only 10 reported measuring the immunization status of adolescents.[112] Similarly, while 32 states are collecting data related to annual well-child visits, only 14 states specifically report collecting data related to annual well-adolescent visits. Even for measures that are relevant for all enrollees regardless of age, such as access to a usual source of care, improving EPSDT screening rates, or increasing Medicaid and SCHIP enrollment, only a small number of states are collecting or reporting these findings by age group, making it impossible to determine if the programs are serving children and adolescents equally well or poorly.

To promote a better understanding of how adolescents use services in Medicaid and SCHIP, and the quality of services that these programs provide:

- The federal government and states should collect, analyze, and report quality and performance data in a consistent and uniform way, by appropriate categories including age group, gender, race, ethnicity, and primary language.
- States working with consumers (including adolescents), purchasers, health plans, and health care professionals with expertise in caring for adolescents should adopt adolescent-specific performance measures designed to monitor clinical effectiveness, use of services, access, and satisfaction with care.
- Quality assurance and performance assessment should include measures that focus on health promotion and prevention, including counseling and screening related to health-compromising behaviors, unwanted pregnancy and sexually transmitted infections, diet, weight, asthma, exercise, depression, and mental health.
- States should require that all purchasers, including Medicaid and SCHIP plans, adhere to the HEDIS guidelines that are specific to or relevant to the care of adolescents.

Conclusion

All adolescents, including those with private insurance, face significant barriers to accessing the care they need. Whether through insurance or other programs, enhancing adolescents' access to health care will require the dedication of a broad array of policymakers, health care providers, researchers, advocates, and consumers, including adolescents and their families. While Medicaid and SCHIP have made a significant impact on adolescents' access to health services, much remains to be done to ensure that these programs reach their potential.

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Care of Children with Special Health Care Needs

Peter G. Szilagyi

One measure of a society's goodness is how well it cares for its children. This standard has particular importance for vulnerable groups of children, such as those facing special health challenges. Thus, the level of care that children with special needs receive through public programs could be seen as a critical marker of the success of the nation's publicly funded health insurance programs. This article reviews the characteristics of children with special health care needs, the types of publicly funded programs that serve them, and the challenges and opportunities involved with providing them with quality health care. It concludes by offering suggestions for improvement, such as enhancing outreach strategies and fostering collaboration across programs.

Who Are Children with Special Health Care Needs?

The term "special health care needs" (SHCNs) has been defined in a number of ways. In general, the children in this category tend to have a high need for services with correspondingly high health care costs. They also rely heavily on special care and ancillary services. In addition, they are especially vulnerable to adverse health outcomes. (See Box 1 for a profile of this group of children.) To plan and evaluate health care coverage for children with SHCNs, policymakers and administrators require information about the size and needs of this population. Yet, no uniformity exists in the way different states or programs identify children with SHCNs.

The number of children who meet the criteria for having SHCNs varies with the definition and the strategy used to identify them. In the past, providers limited their definition to children with specific diagnoses (for example, cystic fibrosis), clear impairments in functioning (for example, blindness), or severe limitations in daily activities. More recently, both the definition of children with SCHNs and the role of programs that serve them have been broadened.[1] By current definition, children with SCHNs are those who have (or are at increased risk for) "chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally," according to the Maternal and Child Health Bureau (MCHB). The broader definition includes children with chronic physical, mental, developmental, and behavioral needs. It also encompasses services not traditionally considered part of the domain of "health care" such as early intervention, school and developmental programs, mental health, social and home care services, and other programs that support families in their caregiving.

Different strategies for identifying children with SHCNs also contribute to varying estimates of the size of this population. In order to aggregate data on this population at the state level, state Medicaid programs

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Box 1

Profile of Children with Special Health Care Needs

- **Prevalence by Demographic Characteristics:** Compared with other children, children with SHCNs are more likely to be over age three, white, and living with parents with low incomes and educational levels.
- **Burden of Illness:** Children with SHCNs have poorer health status and more days in bed or absences from school than other children. The burden upon some families is enormous.
- **Access to Services:** Compared with other children, children with SHCNs seem to have similar rates of health insurance coverage and similar rates of having a usual source of care.[a] However, children with SHCNs have higher rates of unmet health care needs.
- **Use of Services:** Children with SHCNs use more outpatient, inpatient, pharmacy, and ancillary services than other children; some use extremely intensive services.
- **Special Services:** The range of services needed by children with SHCNs varies widely, with many requiring high-technology care, highly specialized services, and extensive ancillary (wraparound) services.
- **Co-Morbidities:** Many children with SHCNs have more than one chronic health problem, and many also have developmental, behavioral, and social problems.
- **Costs:** Because children with SHCNs tend to use services more, the cost of caring for these children is higher than for the general population of children; however, the distribution of costs across types of services varies widely with the diagnosis and severity of illness.
- **Burden of Cost:** Families with children having SHCNs often spend a considerable amount of their own income (as much as 9% to 12%) for expenses not covered by insurance,[b] and they may use up an insurance policy's lifetime limit on benefits.[c]

[a] Having a usual source of care is not the same as having a medical home, but it is a first step (see Box 3).
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generally apply their state's definition[2] to readily available administrative data sets[3] with information on children (such as diagnosis and use of services).[4] To estimate how many children are affected nationwide, surveys or interviews with parents are often used.[5–9] Two studies examined parent responses from a national survey in light of the broad federal MCHB definition of SHCNs, and estimated that from 14.8%[10] to 18.2%[11] of children had special needs. Other approaches tend to identify fewer children. For example, examining insurance plan administrative data[12] or lists of children enrolled in special programs[13] identifies a lower prevalence rate of children with SHCNs.[14]

Reaching a consensus about defining and identifying the population of children with SHCNs would be helpful in designing publicly financed programs to meet their needs, and assessing the quality of care they are provided. Defining this population in a similar manner across states and publicly financed programs is crucial in order to allow program comparisons and trend analyses. In addition, this information would make possible a

. . . the variety of public programs and delivery systems for children with SHCNs poses a difficult challenge in evaluating the overall care of this population.

national effort for broader coverage of children with SHCNs with an adequate benefit structure and services. However, such standardization appears unlikely.[15]

Key Indicators of Program Quality

Beyond identifying the population, a useful strategy for assessing how well publicly funded insurance programs work for children with SHCNs is to examine key indicators of program quality that are unique to these children. Program performance can be assessed in terms of structural characteristics (such as the adequacy of benefit packages, availability of providers, and funding mechanisms), process indicators (such as the level and quality of primary and specialty care provided, and the level of care coordination), and outcome measures (such as the level of health outcomes, and levels of family and provider satisfaction). At the same time, the variety of public programs and delivery systems for children with SHCNs poses a difficult challenge in evaluating the overall care of this population. More study is needed in terms of the impact of different programs, especially the newer State Children's Health Insurance Programs (SCHIP), on the quality of care and health outcomes for these children.

Structural Characteristics

A key indicator of program quality is the structure of the program itself: the type of program and benefits it offers, the providers it makes available, and the way it is funded. Each of these three structural characteristics has important implications for the quality of care provided children with SHCNs.

Type of Program and Benefits

With few exceptions, no universal entitlement program is available for children with SHCNs.[16,17] Instead, a variety of federal, state, and local programs cover these children, including Medicaid, SCHIP, and Social Security Insurance (SSI).[18] (See Box 2.) Such publicly funded programs are an important resource: More than one-third of all U.S. children with SHCNs are likely to be covered by them.[19,20] Even more are likely to be eligible for coverage, but not enrolled. While the number of children with SHCNs enrolled in Medicaid managed care and SCHIP managed care plans increased dramatically in the 1990s, many more children are eligible.[21]

Several studies have examined the adequacy and breadth of the benefit structure of public health insurance programs with respect to children with SHCNs.[22–25] Studies of Medicaid managed care suggest that these programs can improve children's access to a medical home and facilitate tracking of enrollees, but may also limit needed services by constricting benefits, restricting referrals, and creating disincentives for primary care providers to accept children with SHCNs or to manage them optimally.[26] Nevertheless, overall, Medicaid offers the most comprehensive benefit package for these children.

Every state Medicaid program—including every Medicaid expansion SCHIP program—is required to offer Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) health services that cover "medically necessary" diagnostic and treatment services for chronic conditions, and "optional" Medicaid services as long as medical screening deems the services necessary. The latter include wraparound services such as dental care, physical and occupational therapy, prescription drugs, eyeglasses, rehabilitation, social work, and home nursing.[27] While many groups have opposed the wide scope of mandated services under Medicaid, the comprehensive benefit package is beneficial to children with SHCNs. States tend to interpret the "medically necessary" standard broadly, and have provided specifications regarding coverage and service delivery in their managed care contracts.[28] For example, Pennsylvania required Medicaid managed care plans to cover any service that "is reasonably expected to prevent the onset of an illness...or is reasonably expected to reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability."[29]

By contrast, the benefit packages offered by separate SCHIP programs are more limited (see the article by Wysen, Pernice, and Riley on program design in this journal issue). Benefit packages through SCHIP often

Box 2

Publicly Funded Programs Available for Children with Special Health Care Needs

Medicaid: By far the largest public health insurance program with the most comprehensive benefit package for children with SHCNs.[a] In fact, the benefit package in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program was designed with children with SHCNs in mind.[b] Medicaid covers children with SHCNs who are institutionalized and includes coverage of much durable medical equipment and many ancillary services.

SCHIP (or Title XXI): Covers many children with SHCNs now, but benefits vary by the type of program. Medicaid expansion programs have more comprehensive benefit packages for children with SHCNs than programs modeled after commercial insurance plans.[c] Four models of SCHIP that cover children are:[d]

- **Traditional Approaches:** Programs that rely on the basic SCHIP program to serve children with and without special needs.
- **Wraparound Approaches:** Programs that offer supplementary coverage (such as care coordination) and a benefit package that often mirrors Medicaid benefits for children with SHCNs identified by providers.
- **Service Carve-Outs:** Programs that enroll children with special needs in both a SCHIP managed care program and the state Title V (or other special needs) program, so that the oversight, financing, and programmatic responsibilities no longer reside with the managed care plan providing SCHIP coverage.
- **Specialized Systems of Care:** Programs that automatically enroll children in a special state program that is funded and managed separately from the SCHIP managed care plan and is specially designed for them.

Title V of the Social Security Act (via the Maternal and Child Health Services Block Grant): Provides money to states to develop community-based programs for mothers and children. At least 30% of Title V funds must be used for children with SHCNs.[e] Services include case management, coordination of care, home visitation, and family support. States must match three dollars for every four dollars received by Title V, a higher level of state match than required for SCHIP or Medicaid. Some states match even larger amounts, but states vary greatly in their use of Title V funding and covered services.[f]

Supplemental Security Income (SSI): Provides cash assistance to help families meet some expenses related to disabilities, qualifies children for Medicaid, and ensures that children receiving SSI are referred into the state's Title V programs. Children must demonstrate both disability and financial need. Welfare reform legislation of 1996 tightened the definition of "disability," particularly for children with behavioral problems. Children must fulfill two requirements for SSI:[g] They must have (1) a physical or mental impairment that results in "marked and severe functional limitations" and (2) a condition that is expected to last for more than one year or to cause death within a year. The level of disability must be substantial to qualify for SSI. In addition, this benefit is not available to middle-income families, although in most states the income-eligibility requirements for SSI are more liberal than even the SCHIP income limits.[h]

Katie Beckett Waivers: Since 1982, states have applied to the Department of Health and Human Services for state-specific Medicaid waivers (called "Katie Beckett waivers" and "1115 waivers") to apply federal and state funds to cover health care for people with SHCNs who would otherwise be institutionalized or forgo needed care. The waivers vary by state, often involve demonstration projects, and usually include wraparound services.[i]

[a] Stein, R.E.K. Challenges in long-term health care for children. *Ambulatory Pediatrics* (2001) 1:280–88; Leonard, B., Burst, J.D., Sapienza, J.J. Financial and time costs to parents of severely disabled children. *Public Health Reports* (1992) 107:302–12.

[b] National Institute for Health Care Management. *Assuring quality of care for children in Medicaid managed care-EPSDT in a time of changing policy.* Washington, DC: NIHCM, 1995.

[c] American Academy of Pediatrics Committee on Child Health Financing. Implementation principles and strategies for the State Children's Health Insurance Program. *Pediatrics* (2001) 107:1214–20.

[d] Schwalberg, R., Hill, I., and Mathis, S.A. New opportunities, new approaches: Serving children with special health care needs under SCHIP. *Health Services Research (2000) 35:102–11.*

[e] Kaiser Commission on Medicaid and the Uninsured. *Health insurance coverage in America: 2000 data update.* Washington, DC: KCMU, January 2002.

[f] American Academy of Pediatrics. *Legislative and regulatory issue: Maternal and Child Health Block Grant.* Washington, DC: AAP, 1997. Available online at http://www.aap.org/advocacy/washing/maternal.htm. Accessed on December 8, 2001.

[g] American Academy of Pediatrics Committee on Children with Disabilities. The continued importance of Supplemental Security Income (SSI) for children and adolescents with disabilities. *Pediatrics* (2001) 107:790–93.

[h] McManus, M., Flint, S., and Kelly, R. The adequacy of physician reimbursement for pediatric care under Medicaid. *Pediatrics* (1991) 87:909–20.

[i] Family Voices. *Waivers: The Katie Beckett waivers and the 1115 waivers.* Available online at http://www.familyvoices.org/fs/ma-kbw.html. Accessed December 8, 2001.

exclude services that are important to some children with special health care needs such as case management, rehabilitative services, and behavioral health services.[30] In many cases, uncertainty exists regarding the source of payment for certain services. For example, some SCHIP programs consider speech therapy for a child with autism a medical necessity, while others consider it an educational intervention. Similarly, the source of payment for a child who requires a nurse to accompany him to school may be unclear. Nonetheless, public program benefit plans—including both Medicaid and SCHIP programs—are often more comprehensive than the benefit packages of typical commercial plans in the same regions.[31]

Availability of Providers

A key structural aspect of quality of care involves availability of primary care, specialty care, or ancillary health providers for children with SHCNs. As described below, four broad categories of health care providers serve children with special needs. Children with SHCNs may seek services from any of these categories regardless of the type of health insurance coverage they have.

- *Primary Care Providers (Medical Home):* A major goal of health care is for all children with SHCNs to receive comprehensive care within a "medical home," where health care services are "accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally competent."[32] (See Box 3.) Most often, a primary care practice serves as a medical home.

- *Specialty Providers:* Many children with SHCNs require specialty care and rely on multiple pediatric subspecialists and surgical specialists. The amount of service varies widely depending on the child's diagnosis, and some children with major handicapping conditions require extensive specialty care that is extremely costly.

- *Community-Based and Ancillary Providers:* The needs of children with SHCNs often extend beyond traditional primary care and include a wide range of allied health services such as nursing, physical and occupational therapy, speech and developmental supports, and durable medical equipment. In addition, many children with SHCNs have special educational needs, and school-based providers become exceedingly important. Often these services are not funded through the health care system, but through special educational programs mandated by federal law.[33]

- *Safety Net Providers:* A range of academic medical centers, neighborhood health centers, public health clinics, school-based health centers, and other organizations serve low-income populations, offering both ambulatory and inpatient care for no fee to the patient. Because safety net providers rely largely on Medicaid revenues[34,35] and many—particularly those within academic medical centers—offer specialized services for children with SHCNs, they often provide the actual primary and specialty care for children with SHCNs that are covered by publicly funded programs.

National studies have found that more than 90% of children with SHCNs do have a usual source of care, including children with SHCNs enrolled in Medicaid.[36] Recent studies of prototype state insurance programs that were initiated prior to SCHIP also found that more than 90% of children with chronic conditions such as asthma had a usual source of care.[37,38] Although having

Box 3

Importance of a Medical Home for Children with SHCNs

A medical home is not a specific site, but rather a comprehensive approach to providing optimal health care in partnership with children and their parents. Providers at the medical home assist children and families in obtaining comprehensive and other educational and community-based services that are:

- **Accessible**
  - Care is provided in the child's community and available 24 hours a day, 7 days a week.
  - All insurance, including Medicaid, is accepted, and changes are accommodated.
- **Family-Centered**
  - Recognition that the family is the principal caregiver and the center of strength and support for children.
  - Unbiased and complete information is shared on an ongoing basis.
- **Continuous**
  - The same primary pediatric health care professionals are available from infancy through adolescence.
  - Assistance with transitions (to school, home, and adult services) is provided.
- **Comprehensive**
  - Preventive, primary, and tertiary care needs are addressed.
- **Coordinated**
  - Families are linked to support, educational, and community-based services.
- **Compassionate**
  - Concern for the well-being of child and family is expressed and demonstrated.
- **Culturally Effective**
  - The family's cultural background is recognized, valued, and respected.

Source: American Academy of Pediatrics. The medical home. *Pediatrics* (2002) 110(1):184–86. Available online at http://www.aap.org/policy/S060016.html.

a usual source of care is only a first step toward having a "medical home," it is a necessary one. At the same time, children with SHCNs in public programs do not fare as well with respect to the availability of personnel for care coordination and access to specialty care, as further discussed below. Overall, too few specialists are available to serve children covered by Medicaid or SCHIP. Moreover, Medicaid managed care plans often have limited provider networks and require prior authorization for out-of-plan referrals, both of which may hinder access to appropriate specialty care.[39–44]

Funding Mechanisms

Children with special needs who are in publicly funded programs such as Medicaid or SCHIP may be covered by three major funding mechanisms: fee-for-service, managed care, and blended models. Each funding mechanism has both advantages and disadvantages for children with SHCNs, who tend to have a high need for costly services and specialty care.

- *Fee-for-service:* A fee-for-service system pays providers, hospitals, and other health care services a fee based on patient use of services, with more use resulting in greater payments. Sometimes the payments for specific services are negotiated beforehand. Traditional Medicaid is an example of this funding mechanism. A major advantage of fee-for-service arrangements with respect to children with SHCNs, who consume more costly health care services than typical children, is that this arrangement minimizes the incentive toward limiting needed services. However, the system may reward the provision of unnecessary care.
- *Managed care:* This broad term encompasses a variety of funding arrangements. In general, a defined

population is assigned a primary care provider who acts as a gatekeeper responsible for care coordination. Providers can be paid a discounted fee-for-service rate (they may negotiate to receive more if the managed care organization achieves a level of financial success), or they can receive a set amount per patient irrespective of the amount of services used (this is called capitation). An advantage of capitation is the incentive to use only efficient and effective care that results in cost savings. A potential disadvantage, particularly for children with SHCNs, is a tendency to deny needed services and to fail to enroll high-cost patients.

- *Blended models:* A number of programs have experimented with "carve-outs" (see Box 2) that usually include fee-for-service payments for certain components of care (such as prescription medications or mental health services), while applying capitation for other components (such as primary care). Blended models try to incorporate different incentives for providers and patients to reduce the disadvantages of capitation (for example, denial of appropriate services or refusal to care for the chronically ill) and those of fee-for-service arrangements (for example, potential for excessive care).

Currently, although some findings exist, insufficient research evidence makes it difficult to characterize the performance of these different funding mechanisms for the population of children with special needs. One consistent finding, however, is that Medicaid reimbursement for providers has been substantially lower than reimbursement by commercial insurers, making many providers reluctant to care for this population when covered by Medicaid.[45,46] To determine the best types of financing strategies for children with SHCNs, more research is needed.

Process Indicators: Access and Coordination of Care

The promise of a comprehensive benefit package does not necessarily translate into the reality of access to appropriate services.[47,48] Thus, evaluating the process of providing care for children with SHCNs is critical. Several studies have addressed the quality of the processes by which children with SHCNs secure health care, mostly focusing on access to primary and specialty care, and on the continuity and coordination of care.

Access to Care

All publicly and privately funded programs based on current identification methods face the challenge of enrolling eligible children with SHCNs, leading some to perform targeted outreach. The effectiveness of such outreach programs is difficult to judge except to note that fewer children with SHCNs are enrolled in publicly funded programs than expected based on their prevalence within the population.[49,50] One reason is that these children are expensive and difficult to treat, and while program managers want to provide care for eligible children, there are also disincentives to enrolling more children because of the added expense.

An initial step in a program's ability to care for SHCNs is its capability and process of identifying the population. Unfortunately, neither Medicaid nor SCHIP programs tend to utilize special means to identify the population; instead they rely on the existing health care system to identify the population through children's enrollment in programs like Title V or SSI, identification by providers, or via a list of chronic conditions.[51,52] Barriers to identification include the lack of a commonly accepted definition and inconsistent use of screening tools to determine whether children meet the definition's criteria. A qualitative study of different models of Medicaid managed care programs for children with SHCNs in eight states noted that fee-for-service programs were the least able to identify these children.[53]

Nevertheless, it appears that the publicly financed health care system is performing relatively well for children with SHCNs on overall markers for quality of care, although publicly insured programs perform slightly worse than privately insured programs in certain measures. For example, one national study found that the proportion of children with SHCNs who had a usual source of care was the same for publicly and privately insured children, and that the proportion of publicly insured children with SHCNs who missed or delayed medical, dental, or mental health care was similar to privately insured children with SHCNs. At the same time, the study also found that publicly insured children fared worse on other measures of quality such as parental satisfaction with at least one aspect of their child's primary care.[54] However, this finding of less parent satisfaction in public programs may be due to the fact that children with SHCNs who are also poor

have even more complex and significant needs than do privately insured children (who are less often poor).

In addition, some evidence suggests that children with a variety of chronic conditions who are in Medicaid use more services than children with similar diagnoses who are covered by private insurance, including outpatient, emergency services, and home health services.[55] This may be in part due to greater severity of illness among publicly financed children with SHCNs, and does not necessarily reflect better or worse care. In other words, there is no simple answer to the question about whether publicly financed children with SHCNs receive better or worse access to care than privately financed children with SHCNs.

Continuity and Coordination of Care

Two dimensions of quality are particularly important for children with SHCNs: continuity and coordination of care.[56] Research indicates that the provision of comprehensive case management for children with serious chronic conditions can reduce rates of hospitalization and lower overall health care costs.[57] Yet, several studies have demonstrated that many children with SHCNs in both publicly and privately funded programs experience discontinuities in care, insufficient primary care or coordination of care, and gaps in services especially with respect to specialty providers.[58–60]

Continuity of care is important for children with SHCNs because they often have chronic needs for costly services. But inadequate attention has been given to the barriers to continuity of care within publicly funded programs. For example, a significant factor contributing to discontinuity of care is the mandatory waiting period for SCHIP enrollment. Many SCHIP programs have mandatory waiting periods of two to six months during which a child must be uninsured prior to being able to enroll.[61] These waiting periods could present hardships for children with SHCNs because of gaps in services during uninsured months, or because these children may have been previously covered by commercial insurance and therefore would not be eligible for SCHIP because of a lack of an uninsured period. A recent evaluation of the design of SCHIP programs in 15 states[62] found that some states tried to address such potential problems associated with mandatory waiting periods. Six states specifically exempted the waiting period policy depending on whether the medical costs for families were greater than a certain amount. For example, Connecticut waived a six-month waiting period if families paid greater than 5% of their gross income for their prior insurance plan coverage.[63] Other states focused exemptions directly on children with SHCNs. For example, at one time North Carolina waived its two-month waiting-period requirement for families of children with SHCNs, if the prior coverage did not cover the special need (more recently, in October 2001, North Carolina eliminated its requirement of a 60-day period of uninsurance).[64]

Coordination of care is also important to children with SHCNs because of their frequent need for specialty care. A major recent improvement to the coordination of care has been the promotion of providing a medical home for children with SHCNs, with specialists and ancillary providers used as needed. Yet, several studies have found that while most children with SHCNS have a usual source of care, there was evidence of insufficient coordination between primary and specialty care. For example, a recent four-state study of children covered by Medicaid with serious chronic conditions found that most failed to receive care from a subspecialist, even though most of their conditions warranted such

visits annually.[65] This confirms earlier studies[66,67] noting barriers to specialty care among children with SHCNs in publicly financed programs. At the same time, a recent study of children with SHCNs within the Oregon Health Plan managed care program suggests that enrollment in SSI may have facilitated access to specialty care.[68] Also, only a small proportion of children with SHCN failed to receive needed care because of either cost barriers or other reasons.

If primary care providers are to serve children with SHCNs who are in publicly funded programs, they must participate in publicly funded programs, and have adequate personnel to coordinate the children's care. Although the majority of practicing pediatricians participate in Medicaid and SCHIP, low reimbursement rates and high levels of paperwork discourage some from participation.[69] While providers report high levels of organization and coordination of care for children with SHCNs and frequent use of family-centered approaches, care coordination within pediatric practices is often limited by lack of time and resources.[70]

Outcome Measures

Measuring health outcomes and the quality of care for children with SHCNs is challenging. Individual programs must develop goals and outcomes specifically tailored to the needs of particular populations. One set of performance measures, recommended by the MCHB, is listed in Box 4. Another promising strategy for monitoring the quality of publicly financed care for children with SHCNs involves using the Health Plan Employer Data and Information Set (HEDIS),[71] a set of standardized performance measures developed by the National Committee on Quality Assurance (NCQA).[72–74] Other techniques for monitoring health outcomes and the quality of care include provider surveys, consumer surveys, administrative data, surveys tailored for children with SHCNs,[75,76] and commissioned research studies.

Overall, health outcomes of children with SHCNs are clearly lower than outcomes of normal children due to their chronic diseases. Outcomes for children with SHCNs covered by Medicaid may be lower than for children with SHCNs covered by private insurance, although factors other than the performance of Medic-

Box 4

Six Core Outcomes to Measure Successful Care of Children with SHCNs

To improve care for this large population of children and families, the Maternal and Child Health Bureau developed six core outcomes to guide efforts to address the needs of children with SHCNs:

- All children with special health care needs will receive coordinated ongoing comprehensive care within a medical home;
- All families of children with special health care needs will have adequate private and/or public insurance to pay for the services they need;
- All children will be screened early and continuously for special health care needs;
- Services for children with special health care needs and their families will be organized in ways that families can use them easily;
- Families of children with special health care needs will partner in decision making at all levels, and will be satisfied with the services they receive;
- All youth with special health care needs will receive the services necessary to make appropriate transitions to adult health care, work, and independence.

Source: Maternal and Child Health Bureau. *Achieving and measuring success: A national agenda for children with special health care needs.* MCHB. Health Resources and Services Administration. Available online at http://www.mchb.hrsa.gov/programs/specialneeds/measuresuccess.htm. Accessed on January 13, 2003.

Two dimensions of quality are particularly important for children with SHCNs: continuity and coordination of care.

aid may account for these differences. Many studies have described the health status of children with SHCNs, focusing both on children with specific chronic conditions and all children with special needs.[77-79] Several found that children with certain chronic conditions who were covered by Medicaid had worse health outcomes (for example, more hospitalizations, worse health status) than children covered by private insurance.[80,81] But complicating such comparisons are inherent differences in the populations; for example, children covered by Medicaid are more likely than children in private insurance to have more severe diseases, a larger number of chronic problems, and more environmental or social problems.[82] All of these factors may lead to worse health outcomes. Thus, it would be incorrect to state conclusively that poor performance of the publicly financed programs leads to the worse health outcomes among SHCNs. The ultimate health status of children, even those with special needs, is a product of many factors in addition to health insurance, all of which need to be considered when judging the quality of a health care financing program.

Program success also can be evaluated from the point of view of the key partners: parents and patients, providers, and the public programs.[83] According to recent surveys, satisfaction by parents of children with SHCNs in general appears to be relatively high.[84-86] For example, a 1998 survey of families of children with SHCNs found that most parents were satisfied with the overall care by their physicians.[87] However, those covered by Medicaid plans were more satisfied than families of children in private managed care plans (perhaps because of Medicaid's broader coverage). Major problems identified by families in both public and private plans included insufficient care coordination, limited specialty care due to approval requirements by the plan, and difficulty accessing mental health, behavioral health, and home health services.[88] In addition, pediatricians are often dissatisfied by the lack of available subspecialists, obstacles to referrals, and the lack of personnel within primary care practices to perform case management for children with SHCNs.[89-92]

In sum, recent changes in the publicly financed health care system appear to have produced better access to primary care for children with SHCNs, although insufficient access to subspecialty care persists in many cases. Coordination of care remains suboptimal because of inadequate financing and personnel. Standardized instruments and measurement strategies are just now being incorporated and will hopefully be able to better measure the level and quality of care for children with SHCNs. There is an old saying that "what gets measured gets done." Measuring the quality of care for children with SHCNs in publicly financed programs will enable planners, providers, and consumers to make services more efficient and effective, and ensure that the job is done well.

Improving the System of Publicly Funded Programs for Children with SHCNs

While many aspects of the publicly funded system work well for children with SHCNs, improvements could lead to a better quality of care and ultimately to improved health for children with SHCNs. Suggestions for strengthening these programs are outlined briefly below.

(1) **Enhance outreach.** Outreach strategies should be enhanced to enroll children with SHCNs in appropriate health insurance programs. While new outreach efforts for Medicaid and SCHIP seem to have increased enrollment, state SCHIP outreach programs have not specifically targeted children with SHCNs for enrollment.[93] The 10-year plan by the MCHB[94] calls for managed care plans and health care programs to incorporate a systematic process for identifying their children with SHCNs and for tracking and monitoring their care. Having a systematic process for identifying these children is the first step toward effectively managing their care.[95,96]

(2) **Include wraparound services.** State separate SCHIP programs that offer a more restricted benefit package for children with SHCNs compared to Medicaid's should broaden their coverage to include wraparound services that are critical for children with SHCNs, such as dental care, physical and occupational therapy, prescription drugs, eyeglasses, rehabilitation, social work, and home nursing.

(3) **Improve provider networks.** State Medicaid and SCHIP programs should develop effective strategies to ensure the adequacy of provider networks to serve children with SHCNs. State programs should monitor the availability of primary care, specialty care, and subspecialty providers. Public programs should increase access to primary care medical homes, and improve access to subspecialty providers for children with SHCNs by reexamining referral and medical authorization requirements and broadening the provider network. Increased training will also help primary care providers to understand the concept of comprehensive medical homes to ensure that primary care sites meet the criteria for a true medical home.

(4) **Apply appropriate financial incentives.** Programs should consider risk adjustment strategies and carve-outs to more appropriately compensate for the cost of serving the children that have the most severe conditions. Because 10% of children with severe chronic conditions utilize 70% to 80% of children's health expenditures,[97] the financial pressures for publicly financed managed care plans are to avoid these high-cost patients. Risk adjustment strategies offer a solution to the lack of incentives for caring for this expensive population by more appropriately reimbursing plans or providers.[98] These techniques, which are still early in their development for children, incorporate demographic, health status, and diagnostic information to classify individuals in terms of risk of health care expenditures, and to adjust capitation rates,[99] raising reimbursements. If used in conjunction with rigorous quality-assurance monitoring techniques,[100] they may help to develop more appropriate payment strategies for children with SHCNs.

Several state Medicaid programs (for example, Colorado, Maryland, New Jersey, Oregon, and Washington) have already adopted payment systems that vary based on health status of enrollees.[101–103] These systems provide increased payments to Medicaid managed care plans for enrollees who are classified as having serious chronic illness. Increased use of risk adjustment systems is needed, and newer systems are being developed that will better focus on children with SHCNs.[104]

(5) **Support case management.** Publicly financed programs should help with case management and care coordination at the provider level. For instance, they could assist providers with arranging services, provide information to case managers about children's utilization of recommended care (such as filling of prescriptions and follow-up with mental health or subspecialty providers), and increase their funding for case management activities that both improve the functional status of children with SHCNs and reduce the occurrence of complications of chronic conditions that are often costly to treat.[105]

(6) **Develop and disseminate best practices.** Professional organizations and perhaps states should develop "best practices" for serving children with SHCNs among Medicaid, SCHIP, and Title V programs. Descriptions of innovative solutions and program components that appear to work could be disseminated to other states and programs via publications, workshops,[106] and other communications.

(7) **Cross program collaboration.** States should increase collaboration across different funding programs used by children with SHCNs. Stronger ties between state Medicaid programs, SCHIP programs, and Title V programs could enhance identification of children with SHCNs and tracking of their health care.[107] Such coordination, while not specific to children with SHCNs, could particularly benefit this vulnerable population. For instance, increased collaboration across programs at the community level might enhance patient access to specialty care and to wraparound services (two areas that have been problematic for children with SHCNs). Programs could also work with other key child services such as educational and social services.

(8) **Monitor care**. States should monitor the care provided to children with SHCNs to ensure that they are receiving appropriate services through publicly financed programs. Monitoring should include prevalence of these children in the insurance program, access to and use of services, quality of care, presence of unmet needs, satisfaction and health outcomes, costs, and program per-

formance. Monitoring children with SHCNs separately will require a systematic means to define and identify the population of children with SHCNs (including uniform coding mechanisms and definitions of children with SHCNs) and routine assessment of health measures that are critical to children with SHCNs.[108,109]

Conclusion

Children with special health care needs represent an important and large subgroup of children with chronic disorders who are at high risk for suffering adverse outcomes. Although precisely defining this subgroup of children is difficult, around 14.8% to 18.2% of all children face special health challenges. Just as it is critical for health insurance programs to evaluate how successfully they serve adults with chronic conditions such as heart disease and diabetes, so too is it critical to evaluate the success of publicly financed programs in serving the needs of children with SHCNs.

Overall, the publicly funded insurance programs seem to work well for children with SHCNs, who often need wraparound services and subspecialty care. The comprehensive benefit coverage under Medicaid is particularly critical for these children, and separate state SCHIP programs often offer broader benefit coverage than is available under many commercial plans (though not as extensive as under Medicaid). Families with children having SHCNs are generally satisfied with their children's care under public programs. While health outcomes of children with SHCNs tend to be poorer than outcomes of other children, determining the degree to which this gap can be narrowed by the improved performance of insurance programs is difficult because children with SHCNs have underlying chronic conditions that lead to poor outcomes.

Nonetheless, a number of improvements in publicly financed insurance programs could be made to address such issues as the frequent unavailability of specialty providers and lack of coverage for certain services. Possible improvements include more effective outreach to enroll children with SHCNs, better provision of wraparound services, improved provider networks, use of appropriate financial incentives, better support for case management, development and dissemination of best practices for SHCNs, and monitoring care. Continuously monitoring the quality of care for children with SHCNs within publicly financed programs is essential to ensure that they are receiving the services they need. Primary care providers within a medical home need to help coordinate the care for children with SHCNs because these children often require ancillary services. Public programs can assist providers in this care coordination by offering appropriate provider networks, comprehensive benefit packages, monitoring, and coordination of care.

If a measure of society's goodness is how well it cares for its children, and one marker is how well insurance and public programs serve children with SHCNs, then there is still substantial room for improvement before we can feel satisfied that we are doing all we can to help some of our nation's most vulnerable children.

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ENDNOTES

1. McPherson, M., Arango, P., Fox, H., et al. A new definition of Children with Special Health Care needs. *Pediatrics* (1998) 102:137–40. A group of experts sponsored by the Federal Maternal and Child Health Bureau (MCHB) through the Division of Services for Children with Special Health Care Needs, developed and promulgated in 1998 a new definition of children with SHCNs, which has now been endorsed by the American Academy of Pediatrics.

2. Fox, H.B., McManus, M.A., and Austrian, J.S. *An analysis of safeguards for children with special needs in states' Medicaid managed care contracts, 1999.* Issue Brief Number 4, The Medicaid Managed Care Trends Project. Maternal & Child Health Policy Research Center. December 2000.

3. Shenkman, E.A., and Wegener, D.H. *Strategies for identifying children with Special Health Care Needs.* Institute for Child Health Policy. September 2000.

4. These methods include: (a) specific diagnoses, (b) above average use of services (for example, 1 or 2 standard deviations above the mean use of services by the child population), (c) cost-based approaches (for example, expenditures over $5,000 or $10,000 during the past year), or (d) enrollment in a special program for children with SHCNs such as Supplemental Security Income (SSI). Newer and not widely used administrative data based methods involve "classification systems" that use a combination of diagnostic information from claims or encounters to group children into meaningful categories, some of which include children with SHCNs.

5. These methods more closely follow the definition in Box 1, and several excellent instruments are now available. Although this approach is time consuming and most publicly financed health insurance programs have not yet widely adopted it, some programs such as Medicaid programs in Florida and Texas have started using such surveys to identify children with SHCNs.

6. Bethel, C., and Read, D. Child and Adolescent Health Initiative. *Living with illness screener and supplemental survey module: Description and summary of development and testing.* Portland, OR: Foundation for Accountability, May 1999.

7. Stein, R.E.K., Westbrook, L.E., and Bauman, L.J. The questionnaire for identifying children with chronic conditions: A measure based on a noncategorical approach. *Pediatrics* (1997) 99:513–21.

8. Stein, R.E., Silver, E.J., and Bauman, L.J. Shortening the questionnaire for identifying children with chronic conditions: What is the consequence? *Pediatrics* (2001) 107(4):E61.

9. Carmen, K.L., Short, P.F., Farlet, D.O., et al. Epilogue: Early lessons from CAHPS demonstrations and evaluations. *Medical Care* (1997) 37(3 Supplement): MS97–105.

10. Stein, R.E.K., and Silver, E.J. Operationalizing a conceptually based noncategorical definition: A first look at US children with chronic conditions. *Archives of Pediatrics and Adolescent Medicine* (1999) 153:68–74.

11. Newacheck, P.W., Strickland, B., Shonkoff, J.P., et al. An epidemiologic profile of children with special health care needs. *Pediatrics* (1998) 102:117–23.

12. See note 3, Shenkman and Wegener.

13. Hill, I., Lutzky, A.W., and Schwalberg, R. *Are we responding to their needs? States' early experiences serving children with special health care needs under SCHIP.* Available online at http://newfederalism.urban.org/media/op-48_norelease.pdf. Accessed December 4, 2001.

14. A direct comparison of administrative data from several publicly funded health insurance programs versus parent surveys found that nearly one-third of children with SHCNs identified by surveys were missed by using administrative data alone. See note 3, Shenkman and Wegener; note 13, Hill, et al.

15. The Centers for Medicare and Medicaid Services (CMS, formerly HCFA) is currently considering revising the final criteria that it uses to evaluate mandatory managed care waivers, allowing states to develop their own definition of special populations. This will allow states to choose one of several definitions for children with SHCNs, and it is likely that different definitions will continue to be used throughout the United States.

16. However, Medicare covers children with SHCNs with end stage kidney disease.

17. An important caveat is that many adolescents lose coverage under these programs as they transition to adulthood. See the article by Brindis, Morreale, and English in this journal issue for a more complete discussion of health insurance and adolescents.

18. Stein, R.E.K. Challenges in long term health care for children. *Ambulatory Pediatrics* (2001) 1:280–88.

19. Kaiser Commission on Medicaid and the Uninsured. *Health insurance coverage in America: 2000 data update*, January 2002.

20. See the article by Mann, Rowland, and Garfield in this journal issue.

21. Of note, a small percentage of children are covered by both public and private insurance, and many privately insured children still receive some services through public programs such as school programs.

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Reducing Health Disparities among Children

Dana C. Hughes and Sandy Ng

SUMMARY

The ultimate goal of providing public health insurance is to improve the health of low-income children. Yet, acknowledging the limitations of health insurance is important because children's health is shaped by a variety of factors, many of which cannot be influenced by increased access to health care. Health status is also affected by race, language, culture, geography, and socioeconomic class.

This article summarizes current research about what health insurance can and cannot do in three areas: providing access to health care, reducing stress and worry for parents, and improving children's health status. This review reveals several important themes, including:

- A strong link between health insurance and access to care.
- Evidence that health insurance reduces parental stress—both financial and emotional.
- Mixed and inconclusive evidence about the link between health insurance and improved health status.

The authors discuss some of the barriers to improving the health status of low-income children beyond increasing access to health care. They emphasize that ultimately, the underlying social inequities that lead to disparities in health status based on race, income, and education should be addressed.

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Over the past 15 years, federal and state initiatives have significantly expanded health insurance for low-income children, with the goal of increasing their access to care and, ultimately, improving their health status. Yet, low-income children still lag behind their more affluent peers in health and well-being. Socioeconomic level, which is typically expressed in terms of parental income, education, and occupation, is a strong and consistent predictor of health status. Children lower in the socioeconomic hierarchy suffer disproportionately from almost every disease and show higher rates of mortality compared with those in families that are better off.[1-3]

During the 1980s and early 1990s, Congress greatly expanded the Medicaid program so that today, virtually all poor children are eligible for Medicaid coverage. (See the article by Mann, Rowland, and Garfield in this journal issue.) Complementing Medicaid, in 1997 Congress created the State Children's Health Insurance Program (SCHIP) for children in families with incomes too high to qualify for Medicaid, but who still cannot afford private insurance. SCHIP serves fewer children, but is an important source of coverage for those who would otherwise lack it. In addition, a small number of private-sector insurance efforts over the past two decades have sought to extend subsidized coverage to otherwise uninsured children.[4]

The expansion of health insurance eligibility is an important and necessary step in the effort to improve the health status of low-income children—but it is only one of many needed steps. As a result, despite expanded insurance coverage, achieving measurable improvements in the health status of low-income children has proven elusive. To explain the complex social and policy environment that shapes children's health, this article discusses key factors besides health insurance that influence children's health. This article examines how health insurance can and cannot affect these factors—and, consequently, what insurance can do to improve children's health status—and why health insurance expansions are necessary, but not sufficient, to reduce health disparities between high- and low-income children.

Major Influences on Children's Health

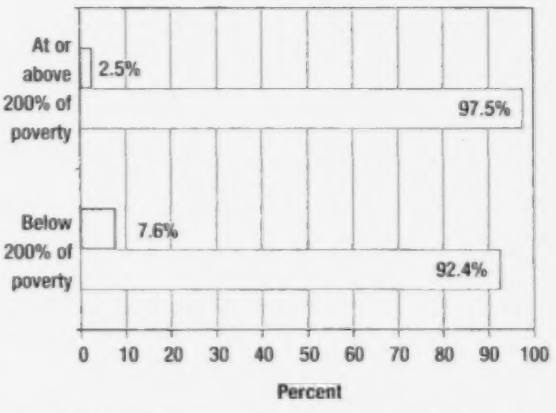
Children's health status, like that of adults, is influenced by many factors in addition to health care, including socioeconomic, biological and genetic, environmental, sociocultural, and behavioral factors.[5] Together, these influences protect children or contribute to poor health or disease.

The primary role of health care (and by extension, health insurance as a means of gaining access to needed care) in influencing children's health status is to prevent and mitigate health problems. Specifically, health care educates families about prevention measures, screens and detects problems as they emerge, and treats those conditions. As important as health care and health insurance are, however, neither influences children's health status as strongly as does socioeconomic status.

Data from the National Survey of America's Families confirm the relationship between parents' income and education and children's health.[6] In 1999, children from low-income families (with incomes below 200%

Figure 1

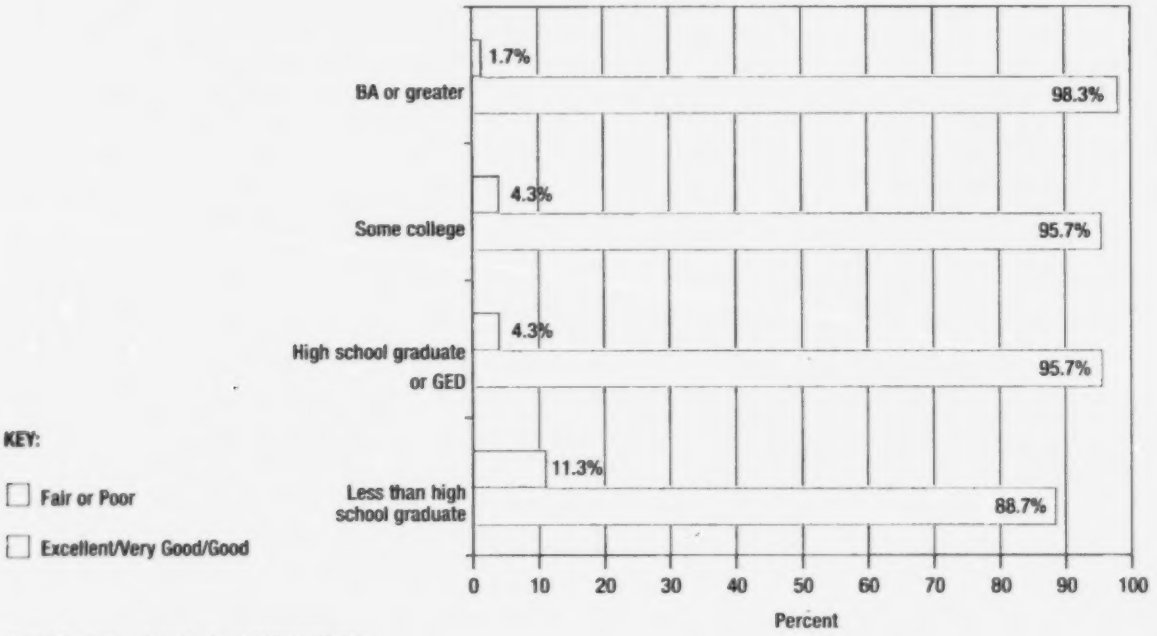
Self-Reported Health Status of Children by Income, 1999



Source: Urban Institute, National Survey of America's Families.

Figure 2

Self-Reported Health Status of Children by Parental Education Level,[a] 1999



[a]For adult most knowledgable about child's health status.

Source: Urban Institute, National Survey of America's Families.

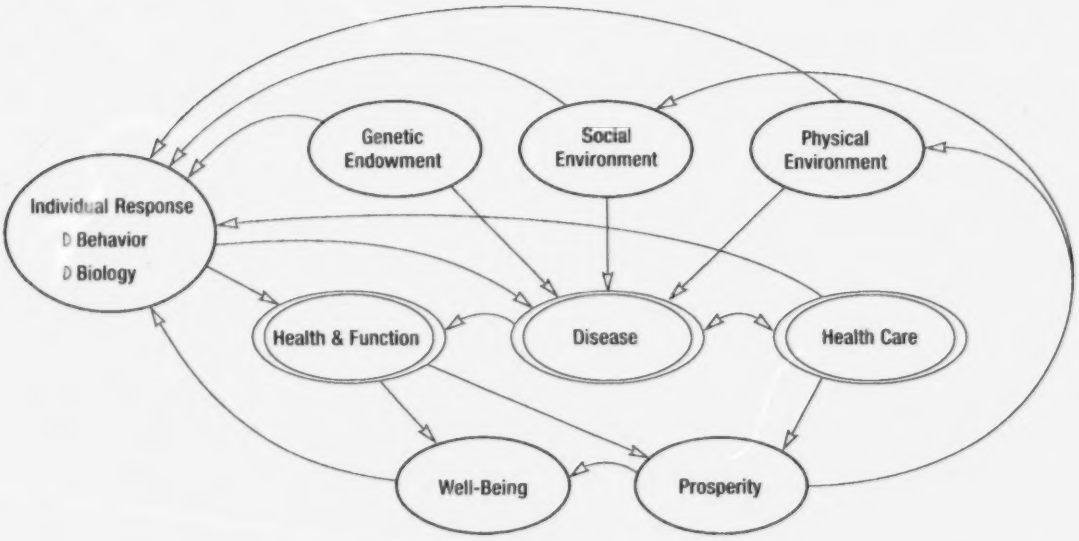
of the federal poverty level) and children whose parents had less than a high school education were far more likely to be in fair or poor health compared with other children. (See Figures 1 and 2.)

Low-income children have higher rates of mortality (even with the same condition),[7,8] have higher rates of disability,[9,10] and are more likely to have multiple conditions.[11] In addition, when low-income children have health problems, they tend to suffer more severely.[12] Children whose parents have lower education levels and lower-paid occupations also tend to have worse health than their more economically advantaged peers.[13–15] Similarly, numerous studies have documented racial and ethnic disparities in health care and health.[16] Even when controlling for income and insurance coverage, racial and ethnic minority children fare worse than white children with respect to such indicators of access to care as presence of a usual source of care, number of physician contacts, and frequency of unmet health needs.[17]

Policies that promote improved access to health care for low-income and minority children address only one of a set of complex factors that influence children's health and well-being. Genetic, environmental, and behavioral factors also play an important role. Health system models that reflect these other factors began to emerge in the 1970s.[18] One frequently cited analysis of these models, published in 1990, builds a comprehensive framework placing health care within the context of all these other factors (see Figure 3). As noted in this analysis, while the relative contributions of these

Figure 3

A Comprehensive Framework of Factors Affecting Health and Well-Being



Source: Evans, R.G., and Stoddard, G.L. Producing health, consuming health care. *Social Science Medicine* (1990) 31(12):1359, figure 5 (with permission from Elsevier Science).

numerous risk factors vary by health condition and by individual, they typically work in combination.

Reflecting the broad array of factors that influence health, in September 1990, the U.S. Department of Health and Human Services launched a comprehensive initiative to improve the health of Americans called Healthy People 2000.[19] Among its 22 priority areas, the initiative included objectives to improve physical activity and fitness, nutrition, and environmental health, as well as the quality of health care services. The second generation of this initiative, Healthy People 2010, launched in January 2000, builds on these objectives and articulates two overarching goals: to increase quality and years of healthy life, and to eliminate health disparities.[20] These comprehensive initiatives recognize that improving health care, while important, is not enough to improve the health and well-being of a population.

The Role of Health Insurance

Health insurance is a vital link to health services in this country, but it has limitations which are important to acknowledge and understand. This section details current understanding about what health insurance can and cannot do in three areas: providing access to health care, reducing stress and worry for parents, and improving children's health status.

Providing Access to Care

Children's health insurance status helps to predict whether they receive needed health care, and provides

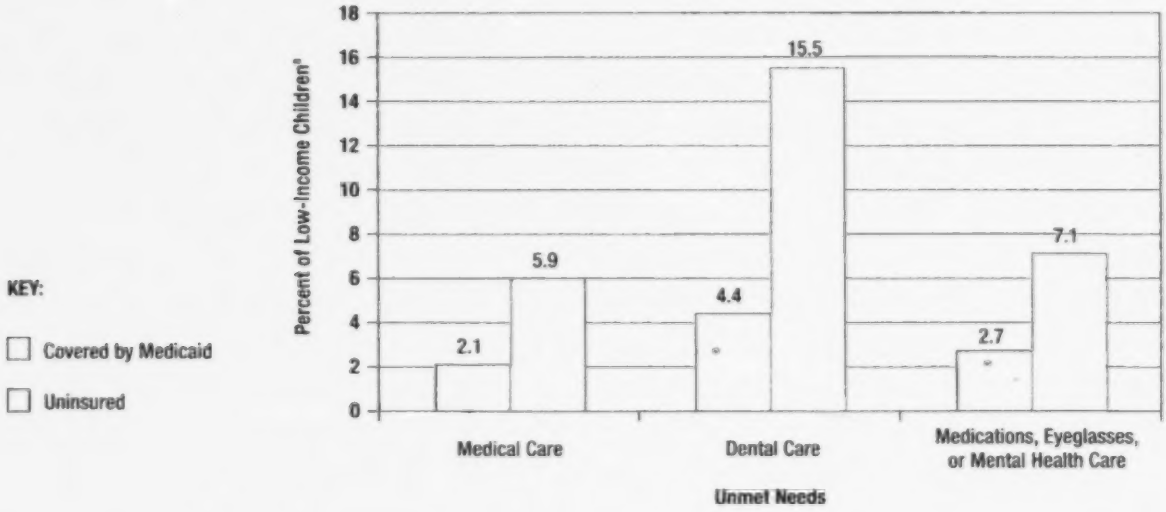
a critical means for identifying and addressing their health problems early in life. Studies consistently demonstrate that children who are covered by health insurance are more likely than their uninsured counterparts to have better access to care, whether measured by number of physician visits, office-based visits, or hospital-based visits, whether a child "enters" the health care system by using health services, or whether a child has a regular source of health care.[21–23]

For example, numerous studies demonstrate, specifically among low-income children, that Medicaid coverage is associated with greater access to care relative to being uninsured,[24–27] and early evidence suggests that SCHIP and its antecedents may produce similar results.[28,29] One study found that, compared to poor children without health insurance, poor children with Medicaid coverage experienced far better access to health care across a variety of dimensions, including presence of a usual source of care (95.6% versus 73.8%) and use of medical services such as one or more physician contacts in the past year (83.9% versus 60.7%).[30] Another recent study found that uninsured children were 8.8 percentage points more likely than those with Medicaid coverage to have no usual source of health care or to rely on the emergency room for routine care.[31] Also, children with Medicaid coverage generally use more preventive services than their uninsured peers do, and are less likely to have unmet needs for care (see Figure 4). Not all studies have found strong effects in this area,[32–35] but one study found that a full year of Medicaid was associated with increases in a child's chances of having any well-child visit by 17%.[36–38]

By improving access to health care, insurance provides a critical means for identifying and addressing health

Figure 4

Unmet Needs for Care among Low-Income Children Covered by Medicaid versus Uninsured



*Low-income children are those in families with incomes below the federal poverty level.

Source: Newacheck, P.W., Pearl, M., and Hughes, D.C. The role of Medicaid in ensuring children's access to care. *Journal of the American Medical Association* (1998) 280(20):1789–93.

problems in children.[39] Children grow and develop rapidly, placing them at special risk of illness and injury. If health problems are not identified and treated, they can affect children's cognitive, physical, behavioral, and emotional development. To prevent or minimize the impact of poor health on overall growth and development, early and frequent monitoring is necessary. Children with undetected and inadequately treated childhood health problems may face the consequences in childhood and later in life. For this reason alone, extending health insurance coverage to improve children's access to health care should be an important public policy goal.

Reducing Parents' Worries

When parents can obtain health insurance for their children, it not only can provide access to care, it also can reduce parents' worries—both financial and nonfinancial—about being uninsured. For example, one study found a significant reduction in parents' restriction of their children's activities due to health-related conditions or concerns after children were insured.[40] In another study of newly enrolled children, 73.5% of the parents reported having been worried, scared, and stressed when their child was uninsured.[41] Over one-third of the parents (36.2%) said that lack of insurance created financial difficulties for the family. Another recent study examined the experiences of children enrolled in SCHIP programs in seven states, and found that the majority of parents (83%) rate the programs as "excellent" or "very good."[42] More than half indicated that they liked the affordability of the program best of all. Therefore, extending insurance to uninsured children has the advantage of relieving parents of the stress and worry that can result from trying to get needed services at an affordable rate. The security provided by health insurance is especially important to parents of the

15% to 18% of children with special health care needs. (See the article by Szilagyi in this journal issue.)

Improving Health Status

The extent to which the Medicaid and SCHIP expansions have improved the health status of low-income children has not been well documented by empirical research. In fact, the available evidence offers somewhat conflicting and inconclusive results. One method for studying the impact of these programs on health is to compare population statistics before and after the Medicaid and SCHIP expansions. These comparisons could potentially reveal evidence of improved health status; however, little such evidence has been found.

For example, one study examined the health status of poor children ages 1 to 12, comparing changes for white, black, and Hispanic children between 1989 and 1995, when an additional 7 million poor and near-poor children were made eligible for Medicaid. Although the number of children with health insurance coverage increased, their health status—measured by parental report of the child's health status and activity in the previous two weeks—did not change.[43] Another study that examined individual-level data from the National Health Interview Survey and state-level aggregate vital statistics of child mortality found that Medicaid eligibility reduced child mortality, but had either no effect or a negative effect on mothers' assessments of their children's health status.[44]

Still another study examined changes in hospitalizations among children ages two to six living in poor residential areas relative to children living in nonpoor areas before and after major Medicaid expansions between 1988 and 1992.[45] The study focused on hospitalizations for ambulatory sensitive conditions (which are health conditions shown to be responsive to access to primary care) that can be prevented or mitigated through primary health care, such as asthma or dehydration. Findings suggested that Medicaid expansions had a positive impact on young, poor children; however, overall, the results of this study were also mixed.

Additional studies have examined the effects on children's health of enrolling in non-Medicaid state health insurance programs. For example, one study found that 25% of parents reported improvements in their child's health as a result of enrolling in a state program targeting uninsured, low-income children not eligible for Medicaid.[46] Another study compared the health status of children 12 months after enrolling in New York's CHPlus (a program for low-income children who were ineligible for Medicaid) to the health status of a comparable group of children newly enrolled in the program. Results indicated that enrollment did lead to health improvements. For example, parents of 55% of children with asthma reported health improvements as a result of office visits and medications received in the year following enrollment in the program.[47]

Beyond studying the differences resulting from health insurance expansions, another approach is to examine whether the cost of insurance contributes to differential health status among children. For example, the Rand Health Insurance Experiment used a randomized, controlled trial to examine the effects of cost sharing on use of health services, quality of care, and health. Insured families faced varying degrees of cost sharing, while uninsured families faced full cost sharing. This study found no significant difference in parents' perceptions of their child's health or in physiologic measures of health between children enrolled in free health insurance plans and those whose parents had varying degrees of responsibility for paying for their child's care.[48] While this study did not look precisely at the relationship between children's health status and insurance coverage, the findings suggest that insurance and co-payments did not play a significant role in influencing health status among the population studied.[49]

In sum, evidence indicates that children's health insurance can provide better access to care and can reduce parents' worries about being uninsured, but whether it can produce health benefits is inconclusive. Although some studies suggest that there might be select benefits for certain groups and individuals, overall, results are mixed and somewhat weak. A number of factors help explain this lack of a strong association between insurance and health status, as explored further below.

Explaining the Weak Link between Health Insurance and Health Status

Despite long-term, major investments in public health insurance, the health status of low-income children continues to lag behind that of more affluent children.

Despite long-term, major investments in public health insurance, the health status of low-income children continues to lag behind that of more affluent children.

Difficulties measuring health status no doubt contribute to the lack of evidence of improved health. At the same time, it is unclear how much improvement may be occurring that simply is not being accurately measured. Beyond the availability of insurance, there are several barriers to improvements in the health status of low-income children, including underenrollment in public programs; inability to mitigate the health effects of low socioeconomic status; noninsurance barriers to health care; and difficulties children face in obtaining appropriate health care, even when some health care is available. To achieve improvements in children's health, these barriers also must be recognized and addressed.

Difficulties Measuring Changes in Children's Health Status

Because children do not have as many health problems as adults do, detecting differences in children's health status is difficult. Compounding the problem is a lack of good methods for measuring children's health status. Health status is typically measured through parental reports (surveys), physical examinations of the child, or reviews of databases such as vital statistics. Each of these options has advantages and disadvantages.

For instance, while relatively easy to collect, self-reports, particularly parental reports of their child's health, are highly subjective and may be too broad to capture improvements or deterioration in status.[50] Clinical examinations are prohibitively expensive on the scale necessary to generate population or even subpopulation estimates. Analyses of inventories and databases such as vital statistics, while more objective than parental reports and less expensive than clinical examination, are complicated by a lack of agreement about what defines "health" and "normal functioning" of children, and of key information on insurance status and income.

Recent efforts to assess the impact of Medicaid expansions on children's health status illustrate these measurement problems. One study used child mortality, an objective measure, to assess the impact.[51] But the rarity of childhood mortality makes it a poor variable for tracking children's health. Moreover, the majority of deaths among children ages 1 to 14 are due to causes that medical care cannot prevent, such as unintentional injuries, congenital anomalies, birth defects, and homicide.[52] Therefore, the usefulness of this indicator of children's health is questionable.

In the study of changes in hospitalizations mentioned earlier, objective measures of ambulatory-sensitive conditions were used to assess the impact of Medicaid expansions on children's health status, a more precise measure than childhood deaths.[53] However, measurement error may have been introduced because of the collection method. Specifically, the authors imputed eligibility status for Medicaid because their data source did not include information about the child's family income, a technique that may have led to misclassifications.

The difficulty of assessing children's health status contributes to the lack of evidence linking expansions of public health insurance to improved outcomes for children. Better measurement systems are needed to clearly demonstrate success. At the same time, better strategies are also needed to address several key barriers to improving the health status of low-income children beyond the lack of insurance.

Underenrollment of Eligible Children

A key contributing factor to the slow progress in improving children's health status is underenrollment in public programs. Despite the availability of Medicaid and SCHIP, not all eligible children are enrolled. In fact, a high proportion of eligible children are not enrolled. For example, more than three-quarters of uninsured children are eligible for public coverage.[54] The article by Cohen Ross and Hill in this journal issue explains various reasons parents do not enroll their children in public health insurance programs, such as burdensome application processes and confusion about eligibility.[55–57] Whatever the reasons, neither improvements in access to health care nor health status can be expected to result from insurance expansions if children are not enrolling in available programs.

Inability to Mitigate Socioeconomic Status

Another reason health insurance expansions may not have strong effects on the health status of low-income children is that low-income families experience many increased risk factors for poor health beyond the lack of insurance. Poverty is strongly associated with multiple risk factors for poor health, including reduced access to health care, poor nutrition, inadequate housing, and greater exposure to environmental threats.[58-61] (See Figure 3.) Among adults, low socioeconomic status is also strongly linked to risky individual behaviors such as smoking, eating a high-fat diet, lack of exercise, and substance abuse—behaviors that clearly affect health status.[62-64] Children are less likely than adults to engage in risky behaviors themselves, regardless of socioeconomic status. Nonetheless, living in homes with parents who engage in these behaviors can influence a child's health, either directly (as with smoking), or indirectly, through correlations with other household characteristics associated with greater risk to children's health, such as lack of parental education or large family size.[65]

Noninsurance Barriers to Health Care

Parents and guardians of children face a number of barriers to health care that no- or low-cost health insurance cannot remedy. These "noninsurance" barriers include both personal and family factors, and structural factors related to the organization of the health care delivery system.[66] While Medicaid may improve access to care for poor children who are otherwise uninsured, it does not ensure their access to the same locations and providers of care, nor the same continuity of care that more affluent children receive. For example, poor children with Medicaid are less likely than nonpoor children (regardless of insurance status) to receive routine care in physicians' offices, and are more likely to lack continuity of providers between routine and sick care.[67]

Personal and Family Barriers to Care

Personal or family factors can pose significant barriers to health care. Parents' knowledge about the importance of health services, their cultural attitudes and beliefs, and competing demands for their time and resources can all influence decisions about whether and when to seek care. While such barriers can be especially acute for immigrants and refugees, personal or family factors that influence health care utilization are found among all populations.[68,69]

For example, parents' knowledge, attitudes, and beliefs about health and well-being can influence their views about what is acceptable in terms of health status and whether or not to seek health care for their children.[70] If parents are unaware of the need for routine check-ups, believe that health services such as immunizations are detrimental, or lack the experience to discern that their child requires medical attention, the presence or absence of insurance becomes relatively unimportant.

Even if provided with low- or no-cost insurance, low-income parents may face difficult tradeoffs in seeking care versus meeting other family needs. For example, many parents would perceive the need to adequately feed, clothe, and house their families as more immediately important than health care.[71] Some scholars argue that the relationship between socioeconomic status and disparities in health status can be explained in terms of demands and resources.[72] Families with lower socioeconomic status face more pressures and problems, such as environmental and occupational exposure to toxins, job-related strains, and stress caused by poverty, but have fewer resources—including money, access to medical care, social supports, and personal coping mechanisms—to meet them.

Immigrants and refugees face particular noninsurance barriers to care (see the article by Lessard and Ku in this journal issue), especially linguistic incompatibility with health care providers and staff and lack of bilingual or multilingual staff, translated materials, and interpreter services.[73,74] Immigrants also cite cultural differences between them and Western health practitioners as a barrier to utilization.[75] A 1992 study of Southeast Asian refugees illustrates the significance of these barriers.[76] Despite a high prevalence of health problems, a number of factors prevented the refugees from seeking care, including beliefs that suffering is an unavoidable part of life, a distrust of Western medicine, and unfamiliarity with Western methods.

For some immigrants, concerns about potential negative ramifications for their immigration status from participating in public programs like Medicaid and SCHIP prevent them from enrolling their children in available programs, and thus from obtaining needed health care. Although the Immigration and Naturalization Service clarified in 1999 that the use of these health services by

an immigrant or family member is not a "public charge" and will not affect immigration status, this information has not reached all eligible families. [77–79]

Structural Barriers to Care

The organization of health services also can affect parents' ability to obtain care, even when the child has health insurance. For example, the physical availability of providers is an important structural barrier, affecting travel time to the service location, the times appointments are available, and the time parents must wait to see the doctor.[80] The organization of services at the service-delivery level (for example, procedures for making appointments and the availability of after-hours services), and at the health-plan level (for example, rules regarding self-referral to specialists, co-payment levels, and the scope of benefits), also influences use of care.[81]

In addition, the type of insurance that a child has (public versus private) can create or eliminate barriers to care. While Medicaid coverage improves children's access to and utilization of care, it does not always provide children with the same access as privately insured children have. Studies show that Medicaid reimbursement levels, which historically have lagged far behind private payment levels, affect the availability of physicians to Medicaid patients,[82] whether a child has a physician's office or a clinic as a usual source of care, and the volume of preventive services received.[83] At the same time, private coverage for low-income children is not necessarily better. In fact, children with private insurance may face greater barriers to health care than low-income children covered by Medicaid, given deductibles, co-payments, and less favorable benefit structures.[84]

Difficulties Obtaining Appropriate Care

Even when children obtain access to health care, that care is not always appropriate, regardless of insurance coverage. Health insurance has been shown to improve access to health care, and to a regular source of care, but not necessarily to a regular source of primary

care.[85] Yet, access to care appears to be most beneficial when it includes primary health care.[86]

Primary care is the entry point into the health care system and facilitates continuing care for most health problems.[87] One of the major benefits of primary care includes establishing a long-term relationship with a particular provider, which leads to better compliance with appointments, better achievement of preventive care goals, and fewer hospitalizations and costs. Another advantage of primary care is patients' ability to obtain health care easily when they need it.

Considerable evidence supports the importance of a regular source of health care, particularly primary care. Having a regular source of care is associated with timely immunizations, preventive care,[88] and other needed health care,[89] as well as satisfaction with that care.[90]

Despite its importance, the primary care infrastructure in the United States—that is, the system- and practice-related features required to deliver primary care—is relatively undeveloped compared with most other industrialized countries.[91,92] Research examining health outcomes and health care costs among 13 industrialized countries scored the countries in terms of the various health system characteristics that reflect strength of primary care orientation.[93,94] The study found that countries with the weakest primary care infrastructures have poorer performance on health status indicators. Overall, the United States ranked 12th among the 13 countries (second from the bottom) on average for 16 health indicators. Furthermore, children in the United States, according to this study, fared particularly poorly. That is, the health disadvantages of this country's underdeveloped primary care system particularly affect children, especially younger children. Failure to substantially improve the health status of U.S. children despite health insurance expansions, therefore, is potentially related to the inadequacy of the primary care system and the inability of insured children to obtain appropriate health care.

In sum, a variety of factors—including measurement issues, underenrollment in programs, poverty's association with multiple other risk factors, family attitudes and beliefs, and health system characteristics—help to explain why the availability of health insurance for low-income children has not had a more significant impact on reducing socioeconomic disparities in children's health status. Overall, access to health care appears to account for relatively little of the association between health and socioeconomic status. The relationship between poverty and poor health is as strong in countries like England, which has universal access to health care, as it is in the United States.[95] Thus, while extending health insurance and removing barriers to care for low-income children is a worthy and essential goal, the extent to which health care alone can reduce socioeconomic disparities in children's health appears to be inherently limited.

Conclusion

Great strides have been made over the past few decades to extend health insurance to low-income children. Policymakers, clinicians, and advocates have sought to extend coverage in order to increase low-income children's access to health care and, ultimately, to improve their health status. Clearly, insurance can provide children the means to obtain needed health care and reassure parents that insurance is available to help them cover health care costs. At the same time, however, health insurance alone cannot reduce the health disparities between high- and low-income children. Differential access to medical care is just one of many factors that account for the disparities in health status between more affluent and low-income children.

Therefore, beyond expanding health insurance coverage for children, further steps will be needed. For example, further work is needed to develop credible and reliable methods of measuring children's health status for use in studies of the relationship between access to care and health status. In addition, nonfinancial barriers to health care that are amenable to policy must be addressed for Medicaid and SCHIP coverage to translate into improved access and greater utilization. These barriers include linguistic incompatibility between patient and doctor, inconvenient location and hours of service, and miscommunication about health care use and immigration status. Also, greater emphasis must be placed on ensuring children's access to primary care through better financing of primary care, greater focus on primary care in medical training, and

other reforms that would strengthen the primary care infrastructure in this country.

Ultimately, however, addressing the socioeconomic gap in children's health will require addressing the underlying inequalities that divide Americans. Otherwise, differences in financial resources will continue to produce differences in nutrition, housing, and coping resources, as well as differences in educational and work opportunities—all factors that have significant effects on children's health. While the goal of greater equality is seemingly utopian, studies show that in developed countries, average life expectancy is correlated with income distribution. The more egalitarian the distribution, the higher the life expectancy.[96] The United States is among the least egalitarian developed countries in income distribution. Achieving true progress will require health professionals and policymakers to join with colleagues in education, work, nutrition, and other related fields to reduce the economic and opportunity inequalities that give rise to the disparities in children's health status, and to develop a more comprehensive policy addressing the full range of factors that affect children's health.

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Program Design and Marketing

EDITOR'S INTRODUCTION

In the "Program Design and Marketing" section, three articles explore different aspects of designing and marketing public health insurance programs for children. These articles range from descriptive overviews of program characteristics and message strategies to an analytical discussion of how to balance conflicting priorities in program design.

In the first article, Wysen, Pernice, and Riley outline how public health insurance programs work, beginning with a description of the spectrum of health coverage available to children. The article then focuses on the two major public health insurance programs for children, Medicaid and the State Children's Health Insurance Program (SCHIP), and compares the major features of each program such as benefit packages, delivery systems, and eligibility requirements. The overview also considers how the programs have complemented and influenced each other. Included in the article are several tables of side-by-side comparisons of each state's Medicaid and SCHIP programs, including comparisons of benefits, cost-sharing requirements, and income-eligibility requirements.

Drawing from a qualitative study consisting of interviews with state outreach officials, the next article, by Perry, describes marketing strategies and key messages that states have used to promote their SCHIP and Medicaid programs. These tactics have included choosing child-friendly names for SCHIP programs (such as Cub Care in Maine) and using emotional appeals in advertising campaigns. Key advertising themes that emerge from this analysis include messages that public health programs are affordable and are designed for working families. The author concludes by considering how future outreach and promotion efforts would benefit from lessons learned from earlier campaigns.

The third article, by Blumberg, considers the challenges of balancing competing priorities in program design. Often the goal of target efficiency (directing as many program dollars as possible to currently uninsured children) conflicts with the goal of horizontal equity (treating children in similar circumstances alike). The author notes that as the programs have evolved, they have influenced each other and the balance between these priorities has

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shifted. For example, while Medicaid initially emphasized target efficiency by limiting eligibility to children whose families qualified for welfare, later expansions, combined with a severing of the link between Medicaid and welfare, enabled the program to provide coverage to children with higher family incomes. Meanwhile, SCHIP emphasized target efficiency by limiting eligibility to currently uninsured children. The article also discusses strategies for achieving each goal, as well as balancing them.

Overall, these three articles provide some insight into the issues that policymakers and program directors must grapple with while trying to effectively design and market public health insurance programs for children. As Perry notes, outreach that encourages families to enroll their eligible children in public programs is only part of the solution. States must also work to ensure that the programs are designed to effectively and fairly deliver needed health care services.

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How Public Health Insurance Programs for Children Work

Kirsten Wysen, Cynthia Pernice, and Trish Riley

Despite the disturbing fact that approximately 9 million children in the United States lack insurance, without public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP), many millions more would be uninsured. Since 1965, Medicaid has provided states with funding and a framework to provide a comprehensive set of health services to needy children and adults. More recently, since SCHIP's implementation in 1997, states have had another tool at their disposal with which to simplify and expand children's coverage. Through state policy decisions, each state has created a unique configuration of services and populations.

This article reviews the entire spectrum of coverage for children in the United States: private and public health insurance, and no health insurance. It places particular emphasis on the main features of Medicaid and SCHIP. The ways that these programs have influenced and benefited each other are also considered, as well as their comparative strengths and weaknesses. In addition, the article discusses innovations that have emerged as states have experimented with different ways to provide health coverage to children. It concludes by considering the implications of increasing fiscal pressures on programs, and the progress that states have made in covering children.

The Spectrum of Children's Health Coverage

Children in the United States receive health coverage from a variety of sources. In general, coverage falls into one of five different categories.[1] As Figure 1 shows, the majority of children (51 million) have private health insurance. Another 18 million children are covered by the two major public health insurance programs: Medicaid (15 million) and SCHIP (3 million); meanwhile, 2 million children have some other form of health coverage, such as military health care or Medicare.[2] Despite the range of coverage options, approximately 9 million children remain uninsured. A range of factors contributes to this problem, including the ways in which programs are designed and implemented.

Private Health Insurance

In 2000, 51 million children in the United States had private health insurance coverage.[3] The majority (94%)

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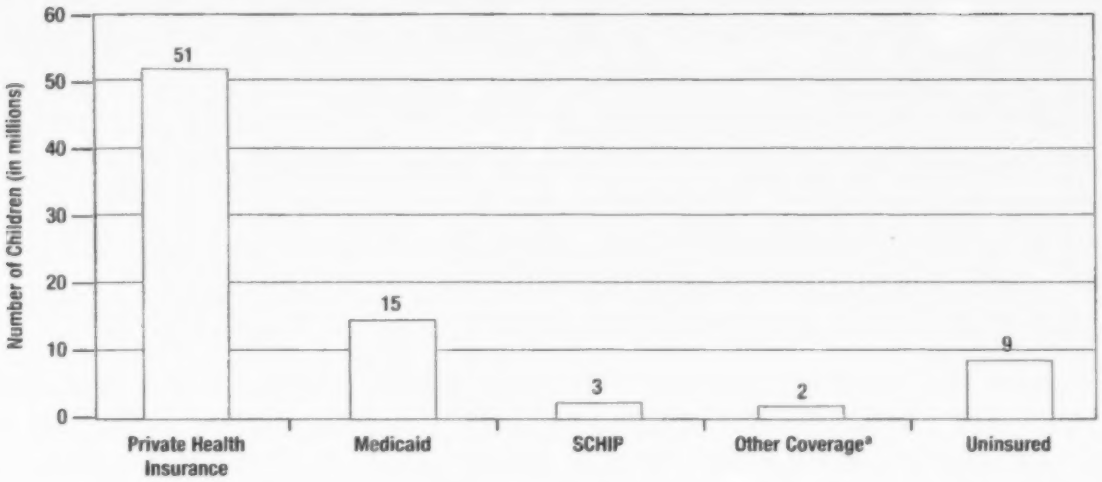
Figure 1

Health Insurance Coverage Status for Children: 2000



[a]Other coverage includes military health care (for example, CHAMPUS/Tricare or CHAMPVA) or health services provided to children in prison or juvenile detention centers.

Note: Some children can fall into more than one category, such as Medicare and private insurance, so the sum exceeds the total number of children. Also, these numbers are lower than often reported elsewhere because Medicaid and SCHIP enrollments are often reported as the total number of children served by the programs over one year. In contrast, this figure represents a snapshot of children under age 18 in various types of health coverage in March 2000.

Sources: Mills, R.J. *Health insurance coverage: 2000.* Washington, DC: U.S. Census Bureau, September 2001. Available online at http://www.census.gov/hhes/www/hlthin00.html; Kaiser Commission on Medicaid and the Uninsured. *Health coverage for low-income children, fact sheet.* Washington, DC: KCMU, May 2002.

obtained this coverage through their parents' employers. The remaining 6% were in families with individual health insurance policies. Most privately insured children were in families with incomes over 200% of the federal poverty level (FPL), or $36,200 for a family of four. In 2000, employer coverage cost $202 per month for an individual and $529 per month for a family.[4] While employers paid most of these premiums, employees paid an average of $54 per month for individual coverage and $180 per month for family coverage.[5] Three-quarters of private health insurance policies had deductibles, and more than one-half of the deductibles were greater than $150 per year.[6] Co-payments of $10 to $20 were typical for office visits.

Private health insurance policies tend to cover physician services, hospital services, prescription drugs, and limited mental health and long-term care services.[7] Transportation, translation, and long-term behavioral health and physical health care services are not included in most private benefit packages. Almost all private health insurance is delivered through some form of managed care, with 38% of enrollees in preferred provider organizations, 28% in health maintenance organizations (HMOs), and 25% in point-of-service plans. Only 9% of policies are delivered through fee-for-service (FFS). More than one-third of all enrollees in employer-based coverage are in self-funded plans.[8]

Medicaid

About one-fifth of American children receive health coverage through Medicaid.[9] A federal program, Medicaid is jointly funded by the federal and state govern-

ments. Overall, the federal government pays 57% of Medicaid costs, and states pay 43%, though the actual matching rates range from 50% to 77%, according to each state's ability to contribute.[10] States administer their own Medicaid programs following statutes and rules set out by the federal government. The federal Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services (DHHS), oversees Medicaid.

Medicaid is an entitlement program, meaning that applicants who meet eligibility criteria will receive coverage. Most children with Medicaid coverage are in very low-income families, usually under 100% or 133% of the FPL, or $17,050 per year for a family of four (see Appendix 1 at the end of this article for a list of Medicaid income-eligibility levels for children). Medicaid enrollees, in most cases, do not pay premiums. The vast majority of children in Medicaid do not have co-payments or other forms of cost sharing. Others in Medicaid can have nominal, very low co-payments (for example, one dollar to three dollars for an office visit).

SCHIP

Enacted in 1997, SCHIP is another federal program jointly funded by the federal government and the states. Its purpose is to cover uninsured children in families with incomes above Medicaid eligibility but below the level needed to afford private coverage (see Figure 2). The federal share of funding is higher for SCHIP than for Medicaid, and states have greater flexibility in administering SCHIP than Medicaid. Overall, the federal government funds 75% of SCHIP costs, and states fund the rest, with actual matching rates ranging from 65% to 84%.[11]

Unlike Medicaid, SCHIP is not an entitlement program. The federal government has budgeted a specific amount per year for the program through 2007. When either state or federal funding limits are reached, states may (and have) impose waiting lists or enrollment freezes on SCHIP.[12]

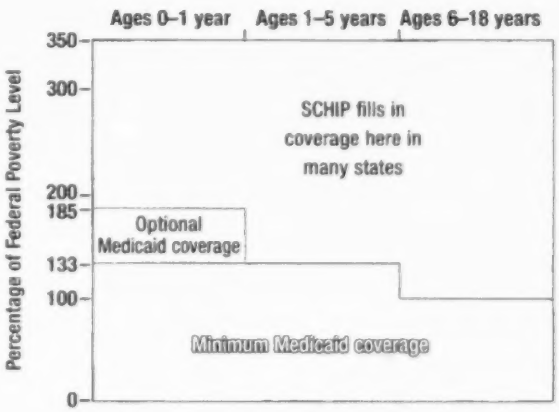
While states may establish their own income-eligibility criteria for SCHIP, and income ceilings range from 133% to 350% of the FPL, about two-thirds of states enroll children in families up to 200% of the FPL (see Appendix 1 at the end of this article). Two-thirds of the states charge monthly or annual premiums, which by law may not exceed 5% of family income (see Appendix 2 at the end of this article for state premium levels). SCHIP enrollees typically make co-payments of five dollars for office visits, with a range from $0 to $15, depending on the state and the family's income (see Appendix 2).

Other Coverage

The U.S. Census Bureau reports that 2.1 million U.S. children obtain health coverage through the military.[13] Military health care includes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services)/Tricare, CHAMPVA (Civilian Health and Medical Program of the Department of Veterans' Affairs), as well as care provided by the Veterans' Administration and the military. An additional half million children qualify for Medicare, usually because of their disability status. Other miscellaneous types of health coverage include health services provided to children in prison or juvenile detention centers. Children of public employees are considered to have private insurance as described above.

Figure 2

Required Medicaid Coverage: 2002



Source: Pernice, C., Wysen, K., Riley, T., and Kaye, N. *Charting SCHIP: Report of the second national survey of the State Children's Health Insurance Program.* Portland, ME: National Academy for State Health Policy, 2001, p. 20.

Uninsured

Although determining the precise number is difficult, approximately 9.2 million children lack health insurance. (See the article by Holahan, Dubay, and Kenney on uninsurance trends in this journal issue.) An estimated 5 million of these children are thought to be eligible for either Medicaid or SCHIP. Two out of three uninsured children (67%) are in families with incomes under 200% of the FPL. More than three-quarters of uninsured children (76%) have at least one parent who works full time.[14]

Uninsured children can obtain health care at hospital emergency rooms, from physicians providing charity care, and from public clinics. Many public clinics receive federal funding. Nonetheless, the parents of uninsured children are more likely than those of insured children to forgo and delay needed health care for their children.[15] Uninsured children are three times more likely than those with Medicaid not to have a regular physician or other type of medical home.[16] Uninsured children are three to six times more likely than their insured peers to go without needed medical care, medications, eyeglasses, or mental health services.[17]

Public Health Insurance Programs: Medicaid and SCHIP

Medicaid and SCHIP have interdependent and, in many ways, mutually beneficial relationships. For example, children can move from one program to the other when their family circumstances change or when they simply grow one year older. Continued close integration of the two programs is needed to assure continuity of care and coverage for low-income children.

In this section, more extensive descriptions of the two programs illustrate how they have benefited from and influenced each other. The section also examines remaining gaps in eligibility, benefits, and other program elements that still need to be addressed.

Medicaid: Entitlement to Coverage for Low-Income Children

In March 2000, Medicaid, the workhorse of public health care programs, covered 15 million children, or one out of every five children in the country.[18] Total state and federal Medicaid spending was $225 billion in 2001, with children's services accounting for $34 billion (15% of spending).[19] Throughout the 1990s, Medicaid programs rapidly adopted managed care for children and other populations, both to increase access to care and to control rising costs.[20] Despite limited resources, many Medicaid programs have carried out extensive quality-assurance activities that focus on improving the health of low-income children. Medicaid programs have also worked diligently and creatively within the resources allotted to them to enhance access for beneficiaries, especially those with specific linguistic, geographic, or cultural needs.

Eligibility

Medicaid was created by Title XIX of the Social Security Act (1965) as an entitlement program to pay for health care services for specific categories of low-income people.[21] The largest federal health program for children, it reached just over 21 million children throughout 2000 and covered one-third of all infants and one-fifth of all children in the United States.[22] Medicaid income-eligibility levels for children vary according to the child's age (see Appendix 1).

The program was enacted to complement federal cash-assistance programs, and most beneficiaries were formerly eligible for income assistance. Over time, and at a greatly accelerated rate during the 1990s with the implementation of welfare reform, Medicaid has evolved into a more freestanding health care program for the traditional categorical eligibility groups and for the more broadly defined working poor. In addition to covering low-income children, for example, Medicaid provides health care coverage for low-income pregnant women, the elderly, people coming off welfare, Supplemental Security Income (SSI) recipients, low-income Medicare beneficiaries, and other, smaller specific groups.[23]

Benefits

Medicaid benefit packages are considered comprehensive. The federal Medicaid statutes specify a set of basic health and long-term care services that must be provided to all enrollees and an additional set of more comprehensive services that are optional for states to provide.[24] In addition to physician, hospital, and nursing home services, Medicaid programs may cover extended mental health and chemical dependency treatment, prescription drugs, and long-term care for people with disabilities.[25] Support services such as medical transportation and translation services are normally covered.[26]

The Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT) for children was established within Medicaid in 1967.[27] EPSDT consists of a comprehensive set of screening services—including vision, dental, and hearing—and the diagnostic and treatment services that result from the screenings. The screening component is similar to a comprehensive well-child visit. The treatment component includes a requirement that states cover an optional benefit if the service is needed to treat a condition identified by an EPSDT screening, even if the state has not chosen to cover that benefit.[28] EPSDT is intended to identify and provide the intervention a child needs to grow and develop to his or her potential. In many states, actual EPSDT screening rates fall far short of 100%. For example, nationwide, only 67% of Medicaid children received at least one screening in 1998.[29]

Cost Sharing

Federal law prohibits nearly all charges to families for services provided under Medicaid. Categorically eligible children, who are eligible because of their families' low income, comprise the vast majority of Medicaid children. They may not be charged for services or required to pay premiums. Only medically needy children, those in higher-income families with significant medical bills, and children in states with waivers to this prohibition can be subjected to nominal cost sharing.

Delivery Systems

Medicaid tends to rely on three different systems for delivering care: managed care, which means enrollment in fully capitated HMOs or prepaid health plans; primary care case management (PCCM), also known as "gatekeeping," in which primary care providers are paid a set amount per month to provide primary care services and make referrals, while other services are paid on a FFS basis; and FFS, in which a fee is paid for each service provided to the beneficiary.[30]

Most states (48 plus the District of Columbia) operate at least one managed care program for Medicaid, while 7 states rely exclusively on PCCM. Two states (Alaska and Wyoming) only use FFS.[31]

In 2000, more than one-half of all Medicaid enrollees (55%) were in managed care, up from 23% in 1994. This trend was primarily motivated by states' interests in con-

trolling Medicaid costs, although improving vendor accountability, clinical quality, and consumer satisfaction are also cited as reasons for expanding managed care.[32] Low-income children and pregnant women were among the first groups to go into managed care in Medicaid. More than 90% of states have had managed care for poverty-level children since 1994. More recently, states have been developing managed care programs for beneficiaries with disabilities.[33,34]

An important issue for Medicaid is the rate at which Medicaid reimburses health care providers for services to children. Relatively low payment rates and additional paperwork make some physicians reluctant to see large numbers of Medicaid patients.[35] Medicaid reimbursement rates vary widely from state to state and service by service, but a recent study found that Medicaid physician payment rates for a set of common services were 64% of Medicare rates, for example.[36] Most Medicaid programs (more than 70%) that contract with managed care plans take age, gender, and eligibility category into account in their payment rates, and more than one-third (36%) adjust payments for health status.[37]

To establish the level at which health care providers are reimbursed for their services, Medicaid programs use four strategies: rate setting, where the state determines what the per-person per-month payment will be; negotiations, where the state and health plans negotiate a monthly payment rate; competitive bids, where health plans submit bids to the state for the monthly payment amounts; and previous performance standards, where the previous year's payment rates are increased by a set percentage.[38] In 2000, 76% of state Medicaid programs used rate setting to pay contracted health plans, 50% used negotiations, 40% used competitive bids, and 17% based payment on previous performance.[39] Several states use more than one payment method (such as using rate setting to establish a payment ceiling and allowing health plans to competitively bid below that rate) to determine their eventual capitation rates.[40]

Outreach and Marketing

Medicaid agencies uniformly work with community-based agencies to conduct outreach and marketing. Most states (70%) use social service agencies, mailings, public meetings, health fairs, and provider offices to inform potential beneficiaries about Medicaid. In 2000, almost two-thirds of states (61%) contracted with other organizations to help enrollees select a health plan, up from 31% of states in 1996.[41]

Quality

States using managed care plans to deliver services to Medicaid beneficiaries are required by federal law to develop and implement a "quality assessment and improvement strategy." For services delivered through FFS, states have more flexibility in monitoring the quality of care; however, they must assure that services "are of high quality."[42]

Medicaid programs using managed care make extensive use of quality-of-care measures. All Medicaid programs contracting with health plans require health plans to submit utilization data and performance measures to the state.[43] The most common measures are those developed by the National Committee for Quality Assurance in the Health Plan Employer Data and Information Set (HEDIS). Almost 90% of Medicaid programs contracting with health plans collect the HEDIS measures, and 71% collect additional state-developed measures. A large majority (more than 80%) collect enrollee survey data and grievance and complaint information and require health plans to carry out their own quality activities. The most commonly used enrollee survey is the Consumer Assessment of Health Plan Study (CAHPS), used by 74% of the states that conduct surveys. In addition, more than 80% of states use the data they collect from health plans to conduct quality studies, identify areas that need improvement, provide feedback to health plans, and make plan comparisons.

All Medicaid programs using managed care are required to contract with an external quality-review organization. The majority of these contracts (83%) are with peer-review organizations. Most external review organizations conduct both random and focused medical chart reviews and validate performance measures reported by the health plans. States also conduct their own monitoring of enrollee hot lines, voluntary disenrollment surveys, state audits, and ombudsman programs.[44]

Access

Almost all Medicaid programs with risk programs consider some access measures when selecting health plans with which to contract. Typical factors include the

extent of the primary care and specialty network, location of providers, number of linguistically appropriate providers, and cultural competence. More than 90% of Medicaid programs use contract language to assure maximum waiting times for appointments, maximum travel times to providers, 24-hour coverage, minimum provider-to-enrollee ratios, and out-of-network access when services cannot be delivered in-network.[45]

Administrative Simplification

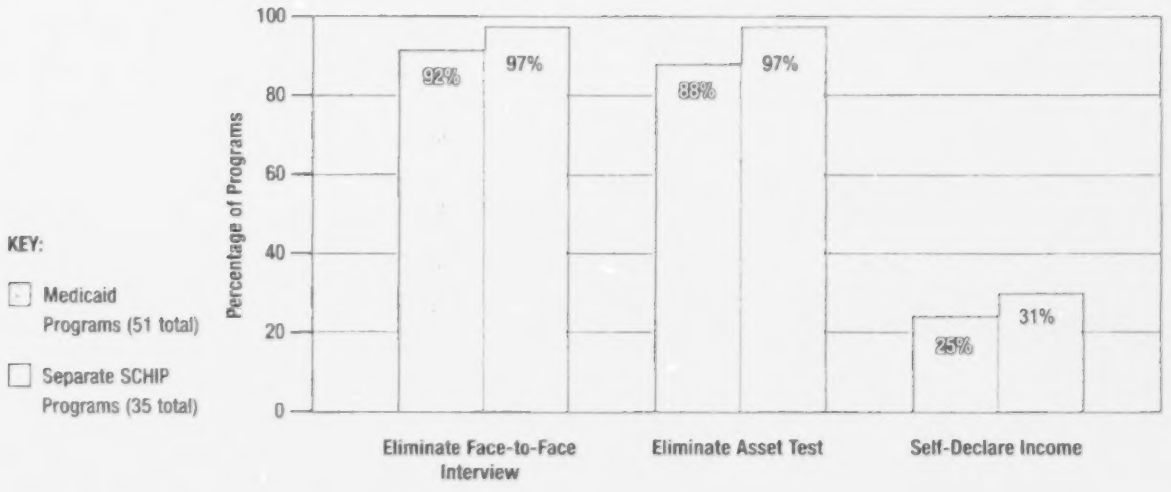
The severing of the link between Medicaid and welfare payments[46] produced simplifications to the paperwork and administrative procedures required for enrollment. Throughout the late 1990s, for example, most states eliminated asset tests and face-to-face interviews for children's Medicaid coverage. (See Figure 3.) Whereas 26 states required asset tests, and 29 required face-to-face interviews to sign up children for Medicaid in 1997, by 2002, these numbers were down to 6 and 4 states, respectively.[47] Removing asset tests can greatly simplify the enrollment process for families, and permitting families to mail in applications rather than go to a state or county office in person makes applying more convenient.[48] In addition, many states no longer require paper documentation to verify income eligibility. In 2002, 13 Medicaid programs accepted self-declaration for income, 43 did so for residency, and 45 did so for the child's age.[49] Instead of paper documentation, programs typically carry out a variety of other verification techniques, such as auditing a sample of enrollees and matching self-reported income with other sources of income data.

Renewal

States also have pursued strategies to simplify the procedures required to renew Medicaid coverage. For example, 42 states provide continuous enrollment to children for 12 months, rather than requiring reapplication at 3 or

Figure 3

Percentage of Medicaid and Separate SCHIP Programs that Have Adopted Selected Administrative Simplification Procedures for Children, January 2002



Source: Cohen Ross, D., and Cox, L. *Enrolling children and families in health coverage: The promise of doing more.* Washington, DC: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2002, pp. 32–37.

6 months or even monthly, as was typically required for cash welfare payments. In addition, a majority of states (48) do not require a face-to-face interview at renewal and allow families to reaffirm their eligibility by mail.[50]

Section 1115 Waivers

Section 1115 of the Social Security Act gives broad authority to DHHS to approve demonstration programs devised by states that cover populations or services not normally covered by Medicaid. As of July 2001, 13 states[51] operated statewide Section 1115 demonstration waivers to cover additional populations. Nine of these states included children in their expansions, usually those in families with incomes higher than the mandatory Medicaid eligibility categories.[52] Five more states operate Section 1115 waivers to provide more services to existing populations; these states are Arizona, Kentucky, Maryland, Ohio, and Oklahoma. In 2000, Section 1115 waivers covered about one-sixth of all Medicaid beneficiaries and accounted for one-fifth of the Medicaid budget nationwide.[53]

SCHIP: Extending Coverage for Low-Income Children

SCHIP was enacted as part of the Balanced Budget Act of 1997. It provides federal matching funds for states to implement health insurance programs for children in families that earn too much to qualify for Medicaid, but too little to reasonably afford private health coverage. Although only five years old, SCHIP has enrolled millions of moderately low-income children, helped streamline Medicaid, marketed itself exhaustively, delivered a fairly generous benefit package, and, from 1998 to 1999, played a part in the first decline in the number of uninsured in the country in 12 years.[54] By December 2001, the fourth year of implementation, SCHIP had enrolled 3.5 million children.[55] SCHIP continues to evolve, and enrollment continues to grow. States are also moving forward with initiatives to further simplify administrative processes and strategies to coordinate SCHIP more closely with Medicaid.

Through SCHIP, states can provide coverage through two different options:

- Create a separate children's health program that meets the requirements specified under Section 2103 of the act, an option known as "separate" or "stand alone" SCHIP; or
- Expand eligibility for benefits under the state's Medicaid plan under Title XIX of the act, an option known as "Medicaid expansion" SCHIP.

States can operate either of these options, alone or in combination. As a result, 16 states have opted to implement only separate SCHIP programs, another 16 states have chosen to expand Medicaid eligibility with a Medicaid expansion SCHIP program, and 19 states have both created separate SCHIP programs and used SCHIP funds to expand Medicaid for children (see Appendix 1).

The variety in SCHIP is created by the flexibility permitted by federal law and the creativity of states implementing the programs. As a result, SCHIP is not one monolithic program, but instead consists of 70 distinct programs (35 Medicaid expansion SCHIP programs and 35 separate SCHIP programs) in 50 states and the District of Columbia. The 35 Medicaid expansion SCHIP programs are basically extensions of states' Medicaid programs, with Title XXI serving as a funding source to expand an existing Medicaid program. Separate SCHIP programs have diverse administration and program designs, and they now have 77% of the enrollment in SCHIP.[56]

Within federal guidelines, each state determines the design of its SCHIP program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. SCHIP provides a capped amount of funds to states on a matching basis for federal Fiscal Years 1998 through 2007.

Eligibility

In general, SCHIP has made income-eligibility levels more consistent for children across the country, with most states (22) setting their SCHIP eligibility level at 200% of the FPL[57] (see Appendix 1). Eligibility levels range from 133% of the FPL in Wyoming to 350% of the FPL in New Jersey.

Despite the increased uniformity of income-eligibility levels resulting from SCHIP, a patchwork of separate state policies dictates how to define critical terms used in determining eligibility, such as "income" and "household members." States use widely different income-disregard policies, which results in people with the same income qualifying for SCHIP differently, depending on where they live.

Benefits

SCHIP health benefits are similar to, but not as comprehensive as, those offered under Medicaid. SCHIP covers physician, hospital, well-baby, and well-child care; prescription drugs; and limited behavioral and personal care services. Beyond those services, the benefit package must demonstrate actuarial comparability to specific benchmark packages, such as the Federal Employee Health Benefit program or the state's employee coverage. For example, in contrast with Medicaid, private-duty nursing, personal care, and orthodontia are usually not covered by SCHIP. Support services such as translation services are often covered by SCHIP, but some states encourage rather than require them. See Appendix 3 at the end of this article for more detail on SCHIP benefit packages and how they compare to Medicaid benefits.

Separate SCHIP programs offer leaner benefit packages than Medicaid. Compared to Medicaid, fewer separate SCHIP programs cover services such as intermediate care facilities, personal care services, and private duty nursing—a reflection of Medicaid's broad benefit package for a disabled population. To compensate for these gaps, some states have developed additional programs for children with special health care needs who would have otherwise been enrolled in SCHIP.[58]

Cost Sharing

SCHIP often requires modest premiums and co-payments. Four out of five separate SCHIP programs require cost sharing, but federal law prohibits cost sharing from exceeding 5% of a family's income. (See Appendix 2 for a list of cost-sharing levels for SCHIP by state.) The types and levels of cost sharing imposed by the programs have evolved over time. While 78% of separate SCHIP programs required premiums in 1998, only 67% did so in 2000.[59] Most separate SCHIP programs have a tiered cost-sharing approach, with higher cost sharing for families with higher incomes (that is, above 150% of the FPL). Co-payments range from $1 for a generic drug prescription to $100 for an inpatient hospital stay.

Maryland, Massachusetts, Rhode Island, and Wisconsin operate employer buy-in programs funded in part by SCHIP funds. In these programs, premiums are paid by employers, employees, and the state. (See the article by Curtis and Neuschler on premium assistance in this journal issue.) With SCHIP funds offsetting some of the costs of coverage, more employer-based coverage may be provided.

Delivery Systems

Like Medicaid, SCHIP uses three systems to deliver care: managed care, PCCM, and FFS. Most (78%) of the 35 states with separate SCHIP programs use some form of managed care to deliver health services. Almost one-half (46%) of SCHIP programs use only HMOs to deliver care, 30% use both HMOs and PCCM, 11% use only PCCM, and 15% use FFS.[60] By contrast, 96% of Medicaid programs use managed care. Five states with separate SCHIP programs (Alabama, North Carolina, North Dakota, West Virginia, and Wyoming) used FFS exclusively in 2000. Two states with separate SCHIP programs (Mississippi and Montana) use only indemnity coverage, and two other states with separate SCHIP programs (Iowa and New York) use indemnity coverage in part of the state.[61]

Outreach and Marketing

SCHIP faced great pressure during early implementation (and the pressure continues today in many states) to show significant enrollment increases. States have shown considerable creativity and energy in their marketing efforts. (See the article by Perry in this journal issue.) Now facing significant budget constraints, most states have directed SCHIP to cut back on statewide advertising campaigns. States typically limit marketing to community-based and school-based outreach programs.

Quality

As SCHIP has matured, states have carried out more activities aimed at assuring the delivery of appropriate, high-quality care for enrollees. By 2000, a vast majority of programs (90%) required health plans to report performance measures, such as HEDIS measures. About 70% of programs also require state-developed performance measures. All the separate SCHIP programs and 90% of the Medicaid expansion SCHIP programs carry out enrollee surveys to measure customer satisfaction.

In addition to health plan reporting requirements, many states contract with an independent quality-review organization to monitor and improve the qual-

ity of care delivered to SCHIP enrollees. Four out of five Medicaid SCHIP programs (83%) and 38% of separate SCHIP programs contract with peer-review organizations. An additional 38% contract with other types of independent quality-review organizations.

States typically monitor the SCHIP enrollee hot line, reviewing call center performance statistics on a regular basis. Similarly, they monitor voluntary disenrollment levels and voluntary health plan switching. Close to one-half of the SCHIP programs perform desk audits of the enrollment activities carried out by health plans. One out of five SCHIP programs requires health plans to obtain accreditation by an outside organization, such as the National Committee for Quality Assurance.[62]

Access

SCHIP programs uniformly examine the capacity of potential health plan contractors to provide adequate access to care, including factors such as location, hours of operation, and cultural competency. Almost all Medicaid and separate SCHIP programs consider the size and location of the primary care providers and specialists participating with the health plans, and they require the health plans to provide 24-hour coverage for enrollees. A large majority of states (85%) use maps to evaluate provider networks in various parts of their states. Three-quarters of SCHIP programs have maximum travel time and maximum waiting for appointment time standards. More than two-thirds of states with risk contracts evaluate how many providers are accepting new patients.

More Medicaid than separate SCHIP programs use cultural competency and linguistic criteria in making their health plan selections. Once contracts are in place, however, a similar percentage of Medicaid and separate SCHIP programs require telephone interpretation, live interpreters, and translation of written materials. Most Medicaid SCHIP and separate SCHIP programs promote the use of traditional safety net providers. Community clinics, family planning clinics, local health departments, maternal and child health clinics, community mental health clinics, and school-based clinics are often promoted in contracts.

Less than one-third of SCHIP programs require health plans to contract with providers experienced in providing care to children with special health care needs.[63]

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Administrative Simplification

SCHIP programs almost universally allow families to mail in their applications or submit them to designated eligibility sites in the community, such as community-based organizations. This method increases access to the programs, because families are not required to schedule and attend interviews with state or county officials.[64] Only one separate SCHIP program (Utah) and four Medicaid expansion SCHIP programs (Alabama, New York, Tennessee, and Utah) still require face-to-face interviews.[65] To further streamline the process, some separate SCHIP programs accept self-reported family income when determining financial eligibility.[66] (Eleven states—Alabama, Arizona, Connecticut, Florida, Georgia, Maryland, Michigan, Mississippi, Vermont, Washington, and Wyoming—accept self-reporting.)[67]

Outsourcing

Two-thirds of states with separate SCHIP programs contract out substantial administrative functions to private contractors. Almost two-thirds of these programs contract out marketing, claims processing, actuarial services, member services, enrollee surveys, and outreach functions.[68]

Renewal

A continuing challenge in both Medicaid and SCHIP is retaining enrollment. Monthly turnover is considerable, particularly at 6- and 12-month renewal periods, as income, family circumstances, and administrative

activities change. SCHIP has sought to assure stability for enrollees through a variety of policies and practices, such as providing 12 months of continuous eligibility, sending preprinted renewal forms, and providing grace periods when premiums are late.[69]

Family Coverage Waivers

Extension of SCHIP coverage to parents of eligible children is only possible with waiver approval from DHHS. On January 18, 2001, the Health Care Financing Administration or HCFA (now CMS within DHHS) approved family coverage waivers from three states: New Jersey, Rhode Island, and Wisconsin. These three states' waivers expanded coverage for low-income families with incomes that exceeded typical Medicaid levels. In addition, New Jersey and Rhode Island expanded coverage to pregnant women. New Jersey has since curtailed its adult enrollment. More recently, in August 2001, CMS launched the Health Insurance Flexibility and Accountability (HIFA) initiative to make it easier for states to cover new populations with unspent SCHIP funds. As of September 2002, Arizona, California, Illinois, Maine, and New Mexico had applied for and received HIFA waivers to cover adults with SCHIP funds.[70]

Conclusion

Medicaid and SCHIP have evolved in an interdependent and mostly complementary way, offering meaningful vehicles for reducing the number of uninsured children in this country. During their initial implementation phase, from 1998 to 2000, many SCHIP programs enjoyed rapid implementation by making use of the extensive infrastructure already developed by state Medicaid programs. For example, several separate SCHIP programs contract with the same health plans, use the same contracts, and use similar quality-assurance techniques as their states' Medicaid programs. Since the late 1990s, Medicaid programs have benefitted from the increased enrollment and marketing activities surrounding SCHIP and, in many states, from the administrative simplification that has come from coordinating with SCHIP.

Among the state laboratories of children's health program experimentation across the country, several examples of success stand out. According to the 2000 U.S. Census, Rhode Island leads the nation in the smallest percentage of uninsured children, with only 2.5% remaining uninsured.[71] Connecticut, Pennsylvania, Tennessee, and Wisconsin are not far behind, all with less than 5% uninsured in that survey.[72] Medicaid and SCHIP are continuing to pursue innovative technology solutions to reach out in low-cost ways to potential enrollees. Five states (California, Georgia, Pennsylvania, Texas, and Washington) have developed sophisticated statewide Web-based online enrollment capacities for Medicaid and/or SCHIP. Arizona, Florida, and Michigan have pilot programs in place.[73]

Through both Medicaid and SCHIP, states have demonstrated that a flexible partnership with the federal government can be rapidly and effectively implemented. With a weakened economy and severe state fiscal situations in the coming years, these successes may be threatened. Furthermore, the fact remains that millions of children in the United States are eligible, but not covered by these programs. Continued efforts will be required at both the state and federal level to face the challenges presented by upcoming funding constraints and to ensure that public health care programs for children strengthen rather than erode in the future.

ENDNOTES

1. Mills, R.J. *Health insurance coverage: 2000.* Washington, DC: U.S. Census Bureau, September 2001. Available online at http://www.census.gov/hhes/www/hlthin00.html.
2. See note 1, Mills; and Kaiser Commission on Medicaid and the Uninsured. *Health coverage for low-income children, fact sheet.* Washington, DC: KCMU, May 2002. Note that some children can fall into more than one category, such as Medicaid and private insurance, so the total exceeds 100%. The figures in this paragraph represent a snapshot of children in various types of health coverage at one point in time. Medicaid and SCHIP enrollments are often reported as the total number of children served by the programs over one year, and those numbers would therefore be higher.
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13. See note 1, Mills.
14. Hoffman, C., and Schlobohm, A. *Uninsured in America, a chart book.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2000, p. 30.
15. Hadley, J. *Sicker and poorer: The consequences of being uninsured.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2002.
16. See note 4, Institute of Medicine, p. 6.
17. See note 14, Hoffman and Schlobohm, p. 67.
18. See note 1, Mills.
19. See note 10, Schneider.
20. Hurley, R., and Zuckerman, S. *Medicaid managed care: State flexibility in action.* Washington, DC: Assessing the New Federalism, Urban Institute, 2002, p. 10.
21. See the article by Holahan, Dubay, and Kenney in this journal issue for more historical information about Medicaid.
22. See the article by Holahan, Dubay, and Kenney in this journal issue. Note that 21 million children were served by Medicaid at some point throughout the year 2000, which is more than the 15 million who were covered in March 2000.
23. Several states that have received federal waivers use Medicaid to cover additional groups, such as the working poor.
24. See note 10, Schneider, p. 53.
25. See note 10, Schneider, p. 53.
26. Kaye, N. *Medicaid managed care: A guide for states.* Portland, ME: National Academy for State Health Policy, 2001, p. 101.
27. Cavanaugh, D., Lippitt, J., and Moyo, O. *Off to a good start, selected federal policies affecting children's social and emotional development and their readiness for school.* Chapel Hill, NC: University of North Carolina, FPG Child Development Center, 2000, p. 115.
28. See note 26, Kaye, p. 40.
29. Health Care Financing Administration. *Annual EPSDT participation report, all states, FY 1998.* Washington, DC: U.S. Department of Health and Human Services, 2000. Available online at http://www.hcfa.gov/medicaid/epsdthin.htm. Accessed on October 1, 2001.
30. See note 20, Hurley and Zuckerman.
31. See note 26, Kaye, p. 3.
32. See note 20, Hurley and Zuckerman.
33. See note 26, Kaye, p. 34.
34. See earlier journal issue on managed health care, *The Future of Children* (Summer/Fall 1998) 8(2).
35. Berman, S., Dolins, J., Tang, S., and Yudkowsky, B. Factors that influence the willingness of private primary care pediatricians to accept more Medicaid patients. *Pediatrics* (2002) 110:239–48.
36. Norton, S., and Zuckerman, S. Trends in Medicaid physician fees, 1993-1998. *Health Affairs* (July/August 2000) 19(4): 222–32.
37. See note 26, Kaye, p. 79.
38. See note 26, Kaye, p. 76.
39. See note 26, Kaye, p. 77.
40. See note 26, Kaye, p. 76. Capitation rate means the per-person per-month payment that plans receive for caring for an enrollee.
41. See note 26, Kaye, p. 57.
42. See note 10, Schneider, p. 142.
43. See note 26, Kaye, p. 120.
44. See note 26, Kaye, p. 121.
45. See note 26, Kaye, p. 90.

46. See the article by Mann, Rowland, and Garfield in this journal issue.

47. Cohen Ross, D., and Cox, L. *Enrolling children and families in health coverage: The promise of doing more.* Washington, DC: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2002, p. viii.

48. See note 47, Cohen Ross and Cox, p. 2.

49. See note 47, Cohen Ross and Cox, p. 36.

50. See note 47, Cohen Ross and Cox, p. ii.

51. The 13 states are Arizona, Arkansas, Delaware, Hawaii, Massachusetts, Minnesota, New Mexico, New York, Oregon, Rhode Island, Tennessee, Vermont, and Wisconsin.

52. Mann, C. *The new Medicaid and CHIP waiver initiatives.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2002, p. 14.

53. See note 10, Schneider, p. 98.

54. See note 2, Kaiser Commission on Medicaid and the Uninsured, p. 2. Note that in 2000 and 2001, the number of uninsured once again started to rise. In 2001, 41.2 million Americans did not have health insurance, up from 39.8 million in 2000 and 39.3 million in 1999. See note 1, Mills.

55. Smith, V., and Rousseau, D. *SCHIP program enrollment: December 2001 update.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2002, p. 1.

56. Centers for Medicare and Medicaid Services. *The State Children's Health Insurance Program quarterly enrollment report, 1/1/2002–3/31/2002.* Washington, DC: Department of Health and Human Services, 2002. Available online at http://www.cms.hhs.gov/schip/fy02sqer.pdf. Accessed on August 16, 2002.

57. Sixteen states have income-eligibility levels below this level, and thirteen have higher levels.

58. Pernice, C., Wysen, K., Riley, T., and Kaye, N. *Charting SCHIP: Report of the second national survey of the State Children's Health Insurance Program.* Portland, ME: National Academy for State Health Policy, 2001, p. 61.

59. See note 58, Pernice, et al., p. 74.

60. See note 58, Pernice, et al., p. 86.

61. See note 58, Pernice, et al., p. 46.

62. See note 58, Pernice, et al., p. 85.

63. See note 58, Pernice, et al., p. 96.

64. See note 47, Cohen Ross and Cox, p. 32.

65. See note 47, Cohen Ross and Cox, p. 32.

66. See note 47, Cohen Ross and Cox, p. 36.

67. See note 47, Cohen Ross and Cox, p. 36.

68. See note 58, Pernice, et al., p. 11.

69. See note 58, Pernice, et al., p. 32.

70. Centers for Medicare and Medicaid Services. *Approved HIFA waivers.* Available online at http://www.cms.hhs.gov/hifa/hifaadem.asp. Accessed on November 25, 2002.

71. U.S. Bureau of the Census. *Historic health insurance tables.* Washington, DC: U.S. Department of Commerce, 2002. Available online at http://www.census.gov/hhes/hlthins/historic/hihistt5.html. Accessed on August 16, 2002.

72. See note 71, U.S. Bureau of the Census.

73. Krause, B. *Enrollment hits the web: How states have maximized internet technology in SCHIP and Medicaid.* Washington, DC: National Governors Association, 2002.

Appendix 1

Income-Eligibility Levels for Children in Medicaid and SCHIP, July 2002

State	Program Eligibility by Child's Age and Federal Poverty Level[a]		
	Medicaid (Title XIX)	Medicaid-Expansion SCHIP (Title XXI)	Separate SCHIP (Title XXI)
Alabama	0–5 up to 133%[b] 6–17 up to 100%	18 from 15% to 100%	0–5 from 133% to 200% 6–18 from 100% to 200%
Alaska	0–5 up to 133% 6–18 up to 100%	0–5 from 133% to 200% 6–18 from 100% to 200%	No program
Arizona	Infants up to 140% 1–5 up to 133% 6–17 up to 100% 18 up to 38%	No program	Infants from 140% to 200% 1–5 from 133% to 200% 6–17 from 100% to 200% 18 from 38% to 200%
Arkansas	0–17 up to 200%	18 up to 100%	State plan approved, but not implemented as of 7/2002
California	Infants up to 200% 1–5 up to 133% 6–17 up to 100% 18 up to 86%	18 from 86% to 100%	Infants from 200% to 250% 1–5 from 133% to 250% 18 from 100% to 250% AIM program[c]: 0–2 from 250% to 300%
Colorado	0–5 up to 133% 6–17 up to 100% 18 up to 39%	No program	0–5 from 133% to 185% 6–17 from 100% to 185% 18 from 39% to 185%
Connecticut	0–17 up to 185%	18 up to 185%	0–18 from 185% to 300%
Delaware	Infants up to 200% 1–5 up to 133% 6–18 up to 100%	No program	1–5 from 133% to 200% 6–18 from 100% to 200%
District of Columbia	Infants up to 185% 1–5 up to 133% 6–17 up to 100% 18 up to 50%	Infants from 185% to 200% 1–5 from 133% to 200% 6–17 from 100% to 200% 18 from 50% to 200%	No program 1–5 from 133% to 200%
Florida	Infants up to 185% 1–5 up to 133% 6–17 up to 100% 18 up to 28%	Infants from 185% to 200% 18 from 28% to 100%	6–18 from 100% to 200%
Georgia	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	No program 1–5 from 133% to 235% 6–18 from 100% to 235%	Infants from 185% to 235%
Hawaii	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	Infants from 185% to 200% 1–5 from 133% to 200% 6–18 from 100% to 200%	No program

State	Program Eligibility by Child's Age and Federal Poverty Level[a]		
	Medicaid (Title XIX)	Medicaid-Expansion SCHIP (Title XXI)	Separate SCHIP (Title XXI)
Idaho	0–5 up to 133% 6–18 up to 100%	0–5 from 133% to 150% 6–18 from 100% to 150%	No program
Illinois	Infants up to 200% 1–5 up to 133% 6–17 up to 100% 18 up to 42%	6–17 from 100% to 133% 18 from 42% to 133%	0–18 from 133% to 185%
Indiana	Infants up to 150% 1–5 up to 133% 6–18 up to 100%	1–5 from 133% to 150% 6–18 from 100% to 150%	0–18 from 150% to 200%
Iowa	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	Infants from 185% to 200% 6–18 from 100% to 133%	1–18 from 133% to 200%
Kansas	Infants up to 150% 1–5 up to 133% 6–18 up to 100%	No program	Infants from 150% to 200% 1–5 from 133% to 200% 6–18 from 100% to 200%
Kentucky	Infants up to 185% 1–5 up to 133% 6–17 up to 100% 18 up to 33%	1–5 from 133% to 150% 6–17 from 100% to 150% 18 from 33% to 150%	Infants from 185% to 200% 1–18 from 150% to 200%
Louisiana	0–5 up to 133% 6–18 up to 100%	0–5 from 133% to 150% 6–18 from 100% to 150%	No program
Maine	Infants up to 185% 1–5 up to 133% 6–18 up to 125%	1–5 from 133% to 150% 6–18 from 125% to 150%	Infants from 185% to 200% 1–18 from 150% to 200%
Maryland	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	Infants from 185% to 200% 1–5 from 133% to 200% 6–18 from 100% to 200%	0–18 from 200% to 300%
Massachusetts	Infants up to 185% 1–5 up to 133% 6–13 up to 114% 14–17 up to 86%	Infants from 185% to 200% 1–5 from 133% to 150% 6–13 from 114% to 150% 14–17 from 86 to 150% 18 up to 150%	1–5 from 150% to 200% 6–13 from 150% to 200% 14–17 from 150% to 200% 18 from 150% to 200%
Michigan	Infants up to 185% 1–18 up to 150%	18 up to 150%	Infants from 185% to 200% 1–18 from 150% to 200%
Minnesota	0–18 up to 275%	0–2 from 275% to 280%	No program
Mississippi	Infants up to 185% 1–5 up to 133% 6–17 up to 100%	18 up to 100%	Infants from 185% to 200% 1–5 from 133% to 200% 6–18 from 100% to 200%

Appendix 1 (continued)

State	Program Eligibility by Child's Age and Federal Poverty Level[a]		
	Medicaid (Title XIX)	Medicaid-Expansion SCHIP (Title XXI)	Separate SCHIP (Title XXI)
Missouri	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	Infants from 185% to 300% 1–5 from 133% to 300% 6–18 from 100% to 300%	No program
Montana	0–5 up to 133% 6–17 up to 100% 18 up to 41%	No program	0–5 from 133% to 150% 6–17 from 100% to 150% 18 from 41% to 150%
Nebraska	Infants up to 150% 1–5 up to 133% 6–18 up to 100%	Infants from 150% to 185% 1–5 from 133% to 185% 6–18 from 100% to 185%	No program
Nevada	0–5 up to 133% 6–17 up to 100%	No program	0–5 from 133% to 200% 6–17 from 100% to 200% 18 up to 200%
New Hampshire	0–18 up to 185%	Infants 185% to 300%	1–18 from 185% to 300%
New Jersey	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	6–18 from 100% to 133%	Infants from 185% to 350% 1–18 from 133% to 350%
New Mexico	0–18 up to 185%	0–18 from 185% to 235%	No program
New York	Infants up to 200% 1–5 up to 133% 6–18 up to 100%	6–18 from 100% to 133%	Infants from 200% to 208% 1–18 from 133% to 208%
North Carolina	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	No program	Infants from 185% to 200% 1–5 from 133% to 200% 6–18 from 100% to 200%
North Dakota	0–5 up to 133% 6–17 up to 100%	18 up to 100%	0–5 from 133% to 140% 6–18 from 100% to 140%
Ohio	0–5 up to 133% 6–18 up to 100%	0–5 from 133% to 200% 6–18 from 100% to 200%	No program
Oklahoma	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	Infants from 150% to 185% 1–5 from 133% to 185% 6–18 from 100% to 185%	No program
Oregon	0–5 up to 133% 6–18 up to 100%	No program	0–5 from 133% to 170% 6–18 from 100% to 170%
Pennsylvania	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	No program	Infants from 185% to 200% 1–5 from 133% to 200% 6–18 from 100% to 200%

State	Program Eligibility by Child's Age and Federal Poverty Level[a]		
	Medicaid (Title XIX)	Medicaid-Expansion SCHIP (Title XXI)	Separate SCHIP (Title XXI)
Rhode Island	0–7 up to 250% 8–17 up to 100%	8–17 from 100% to 250% 18 up to 250%	No program
South Carolina	Infants up to 185% 1–5 up to 133% 6–18 up to 100%	1–5 from 133% to 150% 6–18 from 100% to 150%	No program
South Dakota	0–5 up to 133% 6–18 up to 100%	0–5 from 133% to 140% 6–18 from 100% to 140%	0–18 from 140% to 200%
Tennessee	0–17 up to 400%	18 up to 100%	No program
Texas	Infants up to 185% 1–5 up to 133% 6–17 up to 100% 18 up to 47%	18 up to 100%	Infants from 185% to 200% 1–5 from 133% to 200% 6–18 from 100% to 200%
Utah	0–5 up to 133% 6–18 up to 100%	No program	0–5 from 133% to 200% 6–18 from 100% to 200%
Vermont	0–18 up to 225%	No program	0–18 from 225% to 300%
Virginia	0–5 up to 133% 6–18 up to 100%	No program	0–5 from 133% to 185% 6–18 from 100% to 185%
Washington	0–18 up to 200%	No program	0–18 from 200% to 250%
West Virginia	Infants up to 150% 1–5 up to 133% 6–18 up to 100%	No program	1–5 from 133% to 150% 6–18 from 100% to 150%
Wisconsin	0–5 up to 185% 6–18 up to 100%	6–18 from 100% to 185%	No program
Wyoming	0–5 up to 133% 6–18 up to 100%	No program	6–18 from 100% to 133%
Number of states with program type	51	35	35

[a] Age ranges include the ages specified. For example, "1–5" means children from age 1 up to and including age 5.
[b] Financial eligibility is based on the FPL or a percentage of it. In 2002, 100% of the FPL for a family of three was $15,020; 200% of the FPL for a family of three was $30,040.
[c] The Access for Infants and Mothers Program (AIM) provides low-cost health insurance coverage to uninsured, low-income pregnant women and their infants. California's SCHIP program finances coverage for children ages 0 through 2 whose mothers are enrolled in AIM and have income between 200% and 250% of the FPL.

Sources: Kaye, N., and Flowers, L. *How states have expanded Medicaid and SCHIP eligibility.* Portland, ME: National Academy for State Health Policy, 2002, p. 22; American Academy of Pediatrics. *Medicaid and SCHIP Income Eligibility Guidelines for Children.* Washington, DC: AAP, 2001. Accessed at http://www.aap.org/advocacy/eligibility.pdf on July 19, 2002; Centers for Medicare and Medicaid Services. SCHIP Approved Plan Files. Accessed at http://www.cms.hhs.gov/schip/chpa-map.asp on July 19, 2002; Pernice, C., Wysen, K., Riley, T., and Kaye, N. *Charting SCHIP: Report from the Second National Survey of State Children's Health Insurance Programs.* Portland, ME: National Academy for State Health Policy, 2001, p. 22.

Appendix 2

Cost Sharing in SCHIP Programs, July 1, 2002

State	Premiums Imposed by Federal Poverty Level Range[a]			Co-Payment Amount by Selected Health Care Services[b]						
	100–150%	150–200% FPL	200%	Office visit	Generic prescription drugs	Brand name prescription drugs	Inpatient hospital	Emergency room visit	Dental services	Outpatient mental health
Alabama	None	$50/child/ year, $150 max	NA	$5	$1	$3	$5	$5	$5	$5
Arizona	None	None	NA	—	—	—	—	$5	—	—
California	$7/child/ month, $14 max	$9/child/ month, $27 max	$9/child/ month, $27 max	$5	$5	$5	—	$5	—	$5
Colorado	None	$25/child/ year, $35 max	NA	100–150%: $2 150–185%: $5	$1 $3	$1 $5	—	$5 $15	—	$2 $5
Connecticut	None	None	$30/child/ month, $50 max	$5	$3	$6	—	$25	—	$5
Delaware	$10/family/ month	$25/family/ month	NA	—	—	—	—	$10	—	—
Florida	$15/family/ month, children over 5	$15/family/ month, children over 5	NA	Over 5: $3	$3	$3	—	$10	—	$3
Georgia	$7.50/child/ month, $15 max	$7.50/child/ month, $15 max	$7.50/child/ month, $15 max	—	—	—	—	—	—	—
Illinois	None	$15/child/ month, $30 max	NA	133–150%: $2 150–185%: $5	$2 $3	$2 $5	$2 $5	$5 $5	$2 $5	$5 $5
Indiana	None	$11/child/ month, $16.50 max	NA	—	$3	$10	—	—	—	—
Iowa	None	$10/child/ month, $20 max	NA	—	—	—	—	$25	—	—
Kansas	None	$10/family/ month	NA	—	—	—	—	—	—	—
Maine	None	$5/child/ month, $10 max	NA	—	—	—	—	—	—	—
Maryland	None	None	$40/family/ month	—	—	—	—	—	—	—
Massachusetts	None	$10/child/ month, $30 max	NA	Depends on employer plan						

State	Premiums Imposed by Federal Poverty Level range[a]			Co-Payment Amount by Selected Health Care Services[b]						
	100–150%	150–200% FPL	200%	Office visit	Generic prescription drugs	Brand name prescription drugs	Inpatient hospital	Emergency room visit	Dental services	Outpatient mental health
Michigan	None	$5/family/ month	NA	—	—	—	—	—	—	—
Mississippi	None	None	NA	Over 150%: $5	—	—	—	$15	—	—
Montana	None	NA	NA	$3	$3	$5	$25	$5	—	$3
Nevada	$10/family/ quarter	$25/family/ quarter	NA	—	—	—	—	—	—	—
New Hampshire	None	$20/child/ month, $100 max	$40/child/ month, $100 max	$5	$5	$10	—	$25	—	$5
New Jersey	None	$15/family/ month	$30/family/ month	150–200%: $5 200–350%: $5	$1 $5	$5 $5	—	$10 $35	$5 preventive only	— $25
New Mexico	None	None	None	$5	$2	$2	$25	$15	$5	$5
New York	$9/child/ month, $27 max	$15/child/ month, $45 max	Full premium above 208%	—	—	—	—	—	—	—
North Carolina	None	$50/child/ year, $100 max	NA	Over 150%: $5	$6	$6	—	$20	$5	$5
North Dakota	None	NA	NA	—	$2	$2	$50	$5	—	—
Texas	$15/family/ year	$15/family/ month	NA	100–150%: $2 150–185%: $5 185–200%: $10	— $5 $5	$5 $20 $20	$25 $50 $100	$5 $50 $50	—	$2 $5 $10
Utah	$13/family/ quarter	$25/family/ quarter	NA	0–150%: $3 150–200%: $15	$1 $5	$3 50%[c]	$3 10%	$3 $35	$3 20%	$3 50%
Vermont	None	None	$25/family/ month	—	—	—	—	—	—	—
Washington	None	None	$10/child/ month, $30 max	—	—	—	—	—	—	—

Notes: For ease of readability, if a state has more than one premium per income category, only the lowest premium is given. Delaware, Indiana, Kansas, Maine, Maryland, Nevada, New Jersey, and Texas have additional income bands whose premiums are not listed here. Some states charge premiums that do not fit the income categories of 100% to 150%, 150% to 200%, and more than 200%. New York, for instance, uses income bands of 133% to 185% and 185% to 208%.

[a] A *premium* is charged monthly (Delaware), quarterly (Utah), or yearly (Texas) and is determined as a percentage of income or as a flat rate that may vary by FPL or family size. In 2002, 100% of the FPL for a family of three was $15,020; 200% of the FPL for a family of three was $30,040. In SCHIP, a family will never pay more than 5% of its annual income in cost sharing. Therefore, many states cap premiums by child or family. As an example, in Alabama, a family with income below 150% of the FPL will pay no premiums. A family with income somewhere between 150% and 200% of the FPL will pay $50 per child per year, up to $150 per year per family. For example, if the family has four children enrolled in SCHIP, the family will pay $150 per year.

[b] A *co-payment* is a form of cost sharing in which SCHIP enrollees pay a small fee (typically $5 to $10) each time a service is rendered (such as when a physical examination is conducted or a prescription is filled). Some states' co-payments slide depending on income (Colorado and Illinois).

[c] Utah charges *coinsurance*, which is a portion or percentage of the cost of service SCHIP enrollees pay when a service is rendered (such as 20% of the cost of a $50 service, or $10).

Source: Pernice, C., Wysen, K., Riley, T., and Kaye, N. *Charting SCHIP: Report of the second national survey of the State Children's Health Insurance Program*. Portland, ME: National Academy for State Health Policy, 2001, p. 22, updated to July 1, 2002.

Appendix 3

Program Names and Selected Benefits in Separate SCHIP Programs, as of June 30, 2000

State	Program name/type	Benefit package[a]	Waiting period, in months	Benefits							
				Personal home care services	Private-duty home nursing treatment	Residential substance abuse	Prosthetic devices	Chiro-practic	Hospice	Dental fillings	Speech and occupational therapy
Alabama	ALL KIDS	Largest commercial	3[b]			✓	✓	✓	✓	✓	✓
Arizona	KidsCare	State employee +	3	✓	✓		✓	✓	✓	✓	✓
California	Healthy Families	State employee +	3				✓	✓	✓	✓	✓
Colorado	Child Health Plan Plus (CHP+)	Benchmark equivalent	3						✓		✓
Connecticut	HUSKY Part B	State employee	2				✓	✓		✓	✓
Delaware	DE Healthy Children Program	State employee +	6		✓	✓	✓	✓	✓		✓
Florida	FL KidCare Program	Grandfathered	None	✓	✓	✓	✓	✓	✓		✓
Georgia	PeachCare for Kids	Medicaid	3			✓			✓	✓	✓
Illinois	KidCare Premium	Benchmark equivalent	3		✓	✓	✓	✓	✓	✓	✓
Indiana	Hoosier Healthwise	Medicaid	3				✓	✓	✓	✓	✓
Iowa	HAWK-I	State employee	6				✓	✓	✓	✓	✓
Kansas	HealthWave	State employee +	None	✓	✓	✓	✓	✓	✓	✓	✓
Kentucky	K-CHIP	Medicaid	6[c]	✓		✓	✓	✓	✓	✓	✓[d]
Maine	Cub Care	Medicaid	3	✓	✓	✓	✓	✓	✓	✓	✓
Maryland	MD Children's Health Program Premium	Medicaid	6[c]	✓	✓	✓	✓		✓	✓	✓
Massa-chusetts	MassHealth	Largest commercial	None				✓	✓	✓	✓	✓
Michigan	MIChild	State employee	6		✓	✓	✓	✓	✓	✓	✓
Mississippi	MS Health Benefits Program	State employee +	None			✓	✓	✓	✓	✓	✓
Montana	CHIP	Benchmark equivalent	3			✓				✓	
Nevada	Nevada Check Up	Medicaid	6	✓		✓	✓	✓	✓	✓	✓

State	Program name/type	Benefit package[a]	Waiting period, in months	Benefits: Personal home care services	Private-duty home nursing treatment	Residential substance abuse	Prosthetic devices	Chiro-practic	Hospice	Dental fillings	Speech and occupational therapy
New Hampshire	NH Healthy Kids	Benchmark equivalent	6					✓		✓	✓
New Jersey	NJ KidCare	FEHBP and largest commercial	6		✓	✓	✓	✓	✓	✓	✓
New York	Child Health Plus B	Grandfathered	None	✓						✓	✓
North Carolina	NC CHIP	State employee +	2	✓	✓	✓	✓	✓	✓	✓	✓
North Dakota	Healthy Steps Program	State employee +	6		✓	✓	✓	✓	✓	✓	✓
Oregon	OR CHIP	Medicaid	6	✓	✓	✓	✓	✓	✓	✓	✓
Pennsylvania	PA CHIP	Grandfathered	None			✓			✓	✓	✓
South Dakota	CHIP-NM	Medicaid	3		✓	✓	✓	✓		✓	✓
Texas	TexCare Partnership	State employee	3[b]		✓	✓	✓	✓	✓	✓	✓
Utah	CHIP	State employee	3			✓		✓	✓	✓	✓
Vermont	Dr. Dynasaur	Medicaid	None	✓	✓	✓	✓	✓	✓	✓	✓
Virginia	FAMIS	State employee +	6	✓		✓	✓		✓	✓	✓
Washington	WA CHIP	Medicaid	4		✓		✓	✓	✓	✓	✓
West Virginia	WV CHIP	State employee	6			✓	✓	✓	✓	✓	✓
Wyoming	WY Kid Care	Benchmark equivalent	1					✓	✓	✓	
Total separate SCHIP (35)				12 (34%)	16 (46%)	24 (69%)	27 (77%)	28 (80%)	30 (86%)	32 (91%)	33 (94%)
Total Medicaid (51)				43 (89%)	41 (80%)	38 (75%)	51 (100%)	37 (73%)	45 (88%)	51 (100%)	49 (96%)

[a] According to federal law, SCHIP benefit packages may be based on Medicaid benefits, state employee health benefits, the largest commercial HMO in the state's benefit package, the Federal Employees Health Benefit Program (FEHBP), a benefit package that is equivalent to the above, or a state-designed benefit package that has grandfathered approval for SCHIP.

[b] In Alabama and Texas, the waiting period is 90 days.

[c] In Kentucky and Maryland, the waiting periods noted are used in both SCHIP-funded Medicaid expansion and the SCHIP-funded separate program.

[d] Kentucky covers occupational, but not speech therapy.

Sources: Centers for Medicare and Medicaid Services. *State Children's Health Insurance Program approved plan files.* Available online at http://www.cms.hhs.gov/schip/chpa-map.asp. Accessed on September 5, 2002; Pernice, C., Wysen, K., Riley, T., and Kaye, N. *Charting SCHIP: Report of the second national survey of the State Children's Health Insurance Program.* Portland, ME: National Academy for State Health Policy, 2001, benefits in SCHIP appendix. Waiting period information as of January 2002 from Cohen Ross, D., and Cox, L. *Enrolling children and families in health coverage: The promise of doing more.* Washington, DC: Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2002, p. 39. Medicaid benefits information and totals from Kaye, N. *Medicaid managed care: A guide for states.* Portland, ME: National Academy for State Health Policy, 2001, data CD table: Medicaid Covered Services.

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Promoting Public Health Insurance for Children

Michael J. Perry

Until the State Children's Health Insurance Program (SCHIP) was adopted in 1997, states were not expected to actively promote their public health programs for children or to encourage enrollment. But the availability of new administrative funds under SCHIP for outreach and marketing spurred states to create marketing campaigns to raise awareness about and increase involvement in SCHIP and Medicaid. At the same time, many of these activities were new, and states had little experience in developing marketing materials and advertising campaigns. Over time, however, states gained skill and expertise in promoting their children's health programs.

As states began marketing SCHIP, they also started to focus on enrolling children in Medicaid. Historically, states did not promote Medicaid enrollment because most families were automatically enrolled when they signed up for welfare, or Aid to Families with Dependent Children (AFDC). In 1996, however, welfare reform eliminated the link between eligibility for Medicaid and AFDC, giving Medicaid the opportunity to redefine itself as a health insurance program for low-income families. (See the article by Mann, Rowland, and Garfield in this journal issue.) State advertisements and outreach strategies used to encourage enrollment in SCHIP were also used to encourage enrollment in Medicaid.

This article examines how states marketed their SCHIP and Medicaid programs and identifies lessons learned from these efforts. The article focuses primarily on state advertising and marketing campaigns—since these were such new activities for public health programs that serve children—and less on outreach efforts that occurred at the community level.

To describe state marketing and message strategies, this article draws on a 2000 study conducted for the Kaiser Commission on Medicaid and the Uninsured. The study included in-depth interviews with 55 officials responsible for SCHIP outreach in 48 states (including Washington, D.C.).[1,2] In addition, the study reviewed and analyzed 37 print ads, 24 television ads, and 15 radio ads from 38 states. The purpose of these efforts was to create a baseline of information about states' marketing efforts for SCHIP and Medicaid and to identify common as well as innovative approaches and messages states used. Insights from these interviews and an analysis of state marketing materials for SCHIP and Medicaid form the basis for this article.[3]

The article first discusses the various strategies states used to market their children's health coverage programs. It then reviews the most common messages used to encourage parents to enroll their eligible chil-

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dren in a coverage program, and it briefly discusses efforts to evaluate the effectiveness of state marketing campaigns. Finally, the article concludes with a review of the lessons learned through these efforts and offers suggestions on how these lessons can be incorporated into future children's health coverage campaigns.

Marketing Child Health Coverage Programs

Depending on the type of public health program states implemented, and whether they promoted their public health insurance programs separately or jointly, state officials used a variety of marketing strategies to promote their programs. Strategies included the use of appealing program names, multimedia campaigns, targeted outreach campaigns, and partnerships with community-based organizations (CBOs). (See Appendix 1 at the end of the article.)

New Program Names

Forty-one states gave their SCHIP programs new names (see Appendix 1). Program officials surveyed in the Kaiser study reported creating names that would sound appealing to potentially eligible families and would alleviate some of the stigma attached to government-sponsored programs for low-income families. For example, states gave their programs names that sounded like commercial health plans, such as Healthy Families in California, Partners for Healthy Children in South Carolina, and PeachCare for Kids in Georgia. Other states chose child-friendly names such as CubCare in Maine, Dr. Dynasaur in Vermont, and BadgerCare in Wisconsin.

Joint Promotion

Most states (35 of 48) promoted SCHIP and Medicaid jointly, regardless of whether the state implemented SCHIP as a Medicaid expansion, a separate program, or a combination plan.[4] Thirteen states indicated they promoted only SCHIP, or SCHIP and Medicaid separately, even though they used a joint application. Even when states did not promote Medicaid independently, outreach for SCHIP attracted Medicaid-eligible children and increased Medicaid enrollment.

Multidimensional Media Campaigns

Most states used a combination of television, radio, and print ads, as well as other promotional materials, to market their programs. In the Kaiser study, all 48 states

indicated that they used at least one of these media. The most common medium for promoting children's health coverage was print material (46 of 48 states), followed by radio (41 of 48 states) and television (39 of 48 states). But most states (37 of 48) used all three media to promote their programs.

A number of states placed ads in both local and major newspapers, with ads placed in local newspapers likely most effective. Although major newspapers reach more people in total numbers, state officials believed that their ads were lost amid all the other ads in these papers. On the other hand, local papers are often read from cover to cover, and therefore are more likely to be seen by a great number of people. In addition, ads placed in local papers were often written in languages other than English, enabling states to target eligible people in specific ethnic and language groups.

States used a variety of strategies for their television and radio spots, including both paid and unpaid ads. State officials agreed that paid ads were more effective because they gave the state more control over when the ads would run. In an effort to maximize the effect of the television and radio ads, some states ran them in "flights": on the air for a few weeks, off the air for a few weeks. Many states put their ads on radio stations with a large

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volume of minority listeners, while others blanketed the state with no particular group or location in mind.

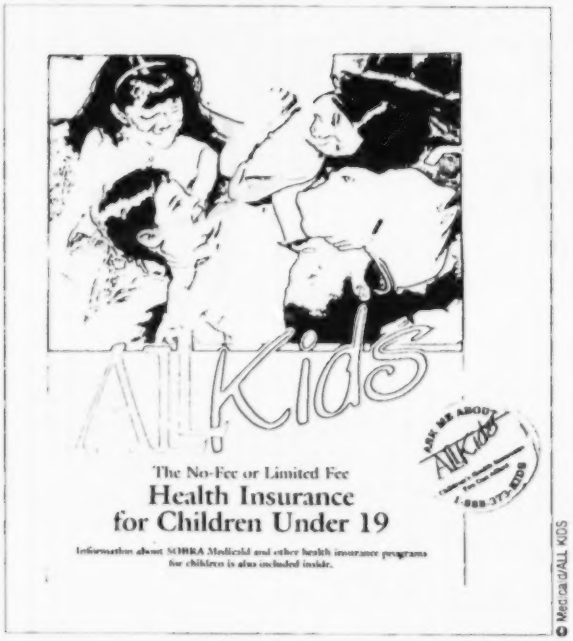
In addition to their formal media efforts, most states used a variety of promotional materials and distributed them in an array of venues (see Box 1). Nearly every state created flyers, pamphlets, posters, or informational booklets to educate people about programs. States also created child-friendly giveaways such as Frisbees, bookmarks, pencils, and key chains to advertise programs. Some states sent direct mailings to individuals, while others placed materials in health clinics, local health departments, day-care centers, schools, libraries, beauty parlors, and Laundromats. Mail-in applications, including phone numbers, were made available in most of these locations. Interested parents could pick up these applications or call if they had questions about the programs.

States developed ads that were aesthetically appealing and polished, with a commercial feel. Most ads used high-quality photography, catchy slogans, bright colors, and appealing tag lines. A few states' ads featured spokespeople, usually the governor. Some ads included doctors and nurses examining children. A few used star athletes. Many print and television ads featured women prominently, showing mothers more often than fathers. Many of the professionals shown—such as medical providers and teachers—were also women.

Box 1

Print Materials Used to Promote SCHIP

- D adhesive bandages
- D adhesive bandage cases
- D answers to "Most Frequently Asked Questions about SCHIP"
- D balloons
- D billboards
- D bookmarks
- D bumper stickers
- D chamber of commerce ads
- D change purses
- D coloring books
- D countertop brochure holders
- D coupons for schools
- D crayons
- D decals
- D dental floss
- D employer bulletins
- D flyers
- D folders
- D Frisbees
- D highlighters
- D large rulers to measure growing children
- D letters to employers asking them to tell employees about SCHIP, with ideas about methods, such as payroll stuffers
- D movie theater ads
- D newsletters
- D newspaper ads
- D pages with outreach and enrollment ideas for community-based organizations
- D pencils/pens
- D pins
- D plastic bags
- D posters
- D prescription pads
- D refrigerator magnets
- D rulers
- D safety covers for electrical outlets
- D sample editorials
- D self-stick notes
- D speaker resource kits
- D tote bags
- D WIC vouchers


ALL Kids
The No-Fee or Limited Fee
Health Insurance
for Children Under 19
Information about SCHIRA Medicaid and other health insurance programs for children is also included inside.
ASK ME ABOUT ALLKids
1-888-KTC-KIDS
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Targeted Promotion

The Kaiser in-depth interviews indicated that nearly two-thirds of states (31 of 48) made efforts to target specific geographic areas and/or specific populations. For example, a number of states targeted select urban areas. In some cases, that meant running ads longer in these markets than elsewhere in the state. Other frequently mentioned target groups included young women, low-income families, Hispanic families, and African American families. A few states also directed efforts toward other groups: pediatricians, migrant workers, pregnant women, organizations working with children, immigrant communities, and rural communities with low enrollment. A few of the more innovative states targeted groups such as former welfare beneficiaries,[5] grandparents,[6] employers, or families of children with special health care needs.

States targeted diverse racial and ethnic populations primarily through print advertising and CBOs. Although states placed SCHIP/Medicaid ads in ethnic media, translated printed materials were the most commonly used targeting tool. Radio and television proved less viable for targeting specific ethnic and racial populations. Instead, states used those media to reach broader statewide audiences with more general messages.

Ads featured children of different racial and ethnic backgrounds—usually African American, Latino, white, and, on occasion, Asian children. Because states wanted to reach many populations with their SCHIP and Medicaid ads, they tended to use multiple photos of children and families of varying racial and ethnic backgrounds, or a single photo showing a diverse group of children. Some states developed targeted supporting materials and posters that showed images of a child and/or a family of a specific ethnic or racial background.

Most states created ads in English and other languages. A majority of states (38 of 48) created at least one radio, television, or print ad in Spanish. At least 6 states translated their print materials into Vietnamese, and almost as many had print ads available in Cantonese. A few states translated materials into other languages as well, including Navajo, Bosnian, Hmong, Creole, Samoan, and Albanian, to name a few. Because of the relative cost-effectiveness, states were most likely to translate printed materials and much less likely to develop radio or television ads in different languages. About one-third of the states created radio spots in Spanish, and a similar number created television ads in Spanish. Because of the expense involved, states rarely developed radio or television spots in any other languages.

A few states targeted employees by featuring employers promoting the state health coverage program. For example, North Carolina's radio ad featured an employer explaining that he was glad his state offered SCHIP to eligible families because he could not afford to provide insurance to his employees. Because most ads targeted working families, informing employers about public avenues for providing health coverage to employees and their families seemed like a good idea.

While most SCHIP and Medicaid ads used images of happy, healthy-looking children in settings such as schools and playgrounds, a few states mixed in images of children with disabilities, special needs, or chronic health conditions, to show that all uninsured children were eligible for the programs. For example, Florida included a child in a wheelchair in its television ad, and Utah's television ad featured a mother talking about her diabetic daughter and how SCHIP enabled her to obtain the care she needs.

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Partnerships with Community Organizations

All states worked with a variety of CBOs in their efforts to reach specific racial and ethnic groups (see Box 2). All state officials interviewed in the Kaiser survey said that they relied on partnerships with CBOs that served diverse communities to reach eligible families. For example, in California, Asian Health Services in Oakland sent Cantonese, Vietnamese, and Korean speakers into the community to describe SCHIP and Medicaid. Many states partnered with school districts not only to distribute informational material but also to educate school employees, especially school nurses, about helping children and their parents understand the importance of health coverage and complete applications. The study indicated that states considered these partnerships with CBOs key to reaching into the community to enroll eligible children in SCHIP and Medicaid.

Box 2

Community-Based Organizations' Partners for Promoting SCHIP and Medicaid

Adoption agencies	March of Dimes
Boys and Girls Clubs	Planned Parenthood
Churches	Schools
Country/state fairs	Tribal health centers
Day-care centers	United Way
Head Start	Women's shelters

Content and Messages Used to Promote SCHIP and Medicaid

To promote their public health programs, states developed a number of content and message strategies using different forms of media. Although the strategies varied across states, some common approaches emerged. For example, overall, states took a "less is more" approach in their ads with regard to program details. Most ads provided only limited information, omitting details about how the programs worked, who qualified, how to enroll, how much programs cost, and what services were covered. For example, only one or two states included income eligibility information in their advertising. Instead, most ads were designed to grab parents' attention and encourage them to obtain more information by calling a hot line. For example, Hawaii's television ad told how much a family of four could earn per month for its children to qualify, and Virginia's print ads included a box with information on how much families of different sizes could earn and still qualify. Some ads did feature specific services that SCHIP and Medicaid cover, such as checkups, medication, hospitalization, and dental care. A few ads even mentioned more specialized care such as vision, speech, and hearing services. Television and radio ads were more likely than print ads to mention specific services, because their formats allowed for more details about the programs.

States appeared split on how to promote SCHIP and Medicaid. While many ads stressed that SCHIP and Medicaid covered doctor visits and hospitalization for ill or hurt children, some ads emphasized the preventive aspects of the coverage, such as having a regular doctor, or highlighted services like checkups and shots.

Key Messages

A review of 37 print ads, 24 television ads, and 15 radio ads promoting SCHIP and Medicaid found that, although states used a variety of messages, several key messages were used across states to promote children's health coverage programs and to motivate parents to learn about the programs and enroll their children. States tended to use a mix of these messages—anywhere from three to five—in a single ad, rather than focusing on one or two messages. The key messages were as follows:

- **SCHIP/Medicaid Is Affordable.** Emphasizing that SCHIP/Medicaid coverage is free or low cost was a prominent message in just about every ad reviewed. The intent was to inform parents that SCHIP and Medicaid are different from expensive, commercial health plans and to reassure parents that they could afford health coverage for their children.

To promote their public health programs, states developed a number of content and message strategies using different forms of media.

- **SCHIP/Medicaid Is for Working Families.** This message sought to differentiate SCHIP and Medicaid from public programs such as welfare, which are not perceived to be for working families.[7] Ads showed middle-class, suburban surroundings to emphasize that SCHIP and Medicaid are for working people who pay taxes and live next door. This message was often supported by a photograph of a working mother in a business suit or a family standing in front of its own small business. States appear to have deliberately chosen an approach that resonates with working families, who may not be comfortable with government assistance programs. Indeed, some ads made no direct reference to the state at all, or did so only subtly.

- **Health Coverage Is Necessary for Children to Thrive.** Many ads emphasized that health coverage is a basic need for children. This message linked success in school to health and stressed that if children are not healthy, they cannot learn and engage in other childhood activities. By depicting health coverage in this way, this message equated health insurance with other essential needs such as food, clothing, and shelter—basics that parents must provide for their children—and urged parents to give greater priority to obtaining health coverage for their children.

- **If You Enroll Your Children, You Will Have Peace of Mind.** A theme that appeared in many ads referred to parents' worries about their uninsured children. Accompanying this theme were images of children riding skateboards or falling from monkey bars at the park. Some ads used emotional appeals to motivate parents to enroll their children, using words such as "frightening" and "scary" to describe how it feels to be the parent of an uninsured child. This message implied that children were likely to get hurt and encouraged parents to seek out coverage before accidents happened.

- **It's Easy to Enroll.** Almost every ad emphasized that enrolling in the programs would be easy. Research has shown that Medicaid's complicated enrollment process has been a significant barrier to enrolling eligible children (see the article by Cohen Ross and Hill in this journal issue). SCHIP and Medicaid ads emphasized that enrollment was quick and easy and implied that it could even be done over the phone.

- **Health Coverage Is Just Too Expensive Today—You Are Doing the Best You Can.** A number of ads mentioned that health coverage is too expensive for working families, thereby identifying cost, not parental neglect, as the main reason some children lack coverage. Ads went to great lengths to avoid any implication that parents were to blame for their children being uninsured, or that parents even had a choice in the matter.

- **You Can Take Your Sick Children to the Doctor Right Away.** Some ads targeted parents who delayed getting medical care for their uninsured children because they could not afford it. Images such as a sick girl on a swing or a mother nursing a sick child in bed accompanied this message. The point is clear: Health coverage enables parents to bring children to a doctor as soon as they become ill, rather than postponing medical care until a child's illness worsens.

- **This Is a New Program.** This message was subtly portrayed in ads, and it emerged more in what was left unsaid. For example, many ads made no mention of links to Medicaid—even when states had created a combination Medicaid/SCHIP program. In addition, most print and television ads used visual images that contrasted sharply with stereotypes of welfare and Medicaid recipients. That is, the ads showed images of working people in middle-class settings and suburban neighborhoods.

- **Your Child Will Have His or Her Own Doctor.** This theme emerged in many ads and stressed the importance of having a regular pediatrician caring for children, as well as the benefits of preventive care. This message spoke directly to the problem of inconsistent and delayed medical care for uninsured children, who often go to emergency rooms or low-cost clinics to

receive medical services. This message, therefore, presented an appealing alternative to parents—a regular doctor who will care for their children—and tapped into a potentially powerful motivation for parents to enroll their children in SCHIP and Medicaid.

- **You Can Have a Choice of Providers.** Some ads stressed that parents would have a choice of providers if they enrolled their children in SCHIP or Medicaid, and that they would not be randomly assigned to a doctor or insurance plan. These ads implied that a number of physicians participated in the programs, dispelling some older images of a limited choice of doctors under Medicaid.

Market Testing and Evaluating Effectiveness

Although slightly less than one-half of states used market-testing techniques to develop their campaigns, almost two-thirds of states made some effort to evaluate their marketing programs after they were implemented.

With regard to market testing, 22 of 48 states in the Kaiser study reported conducting formal or informal market testing to help develop their campaigns. Moreover, officials in states that did not conduct market testing reported that they wished they had and planned to do so for future campaigns. A desire to get information out to the public as soon as possible was cited as a central reason for not conducting market tests.

While more than two-thirds of states reported making efforts to assess the effectiveness of their marketing campaigns, methods varied significantly across states, and definitive findings were few.[8] Nonetheless, the evaluations commonly found that most people who contacted the state about SCHIP or Medicaid did so because a family member or friend had told them about the program. Television was also frequently cited as a source of information about SCHIP and Medicaid, as were schools, doctors, and nurses. This finding suggests that informal communication networks are an important source of information sharing.

Another independent study evaluated the impact of television ads by tracking telephone calls coming in to a national hot line, as well as calls to hot lines set up in six target markets. A significant increase in callers followed television advertisements about SCHIP and Medicaid.[9] Calls to the national hot line increased from an average of 15,000 per month to 58,000 calls in the month ads ran. The six target markets also saw a steep increase in callers, from 74% on the low end to 645% on the high end. These data show that television ads can have a big impact in terms of raising awareness of public health programs and in spurring parents to pursue enrollment.

Lessons Learned

States are no longer making such concerted efforts to advertise public health programs for children. Since 2000, when most of the data for this article were gathered, lack of funding, budget shortfalls, and higher-than-expected Medicaid and SCHIP enrollment and costs per enrollee have led to much less emphasis on marketing campaigns for public health programs for children.[10] Yet important lessons can be gleaned from states' initial efforts to market their SCHIP and Medicaid programs, and these lessons may inform future efforts to raise awareness and encourage enrollment in children's health coverage programs. Effective methods include:

- Using appealing images of diverse children of various ages, including children with disabilities;
- Emphasizing that children's health programs offer free or low-cost health coverage;
- Mentioning covered services that parents want for their children, such as dental care, medications, doctor visits, hospitalization, vision care, and speech services;
- Telling parents that they can have peace of mind knowing that their children are no longer uninsured;
- Making contact information—phone numbers and Web site addresses—very prominent in advertisements;
- Focusing on working families, but not forgetting families leaving welfare or former Medicaid beneficiaries; and
- Giving actual dollar amounts that families can earn and still have their children qualify for the program. Families will be surprised to see how much they can earn and still have eligible children.

Furthermore, although marketing and outreach activities have been curtailed, two major health-coverage-marketing efforts have occurred since the Kaiser study in 2000. One is the Covering Kids Initiative, sponsored by the Robert Wood Johnson Foundation, which continues to help states market SCHIP and Medicaid. In recent years, the program has developed print materials, ads, radio spots, events, and strategies to coincide with the back-to-school season.[11] For example, the program offers states a toolkit for reminding parents about health coverage as they prepare their children for the next school year. The materials tend to use the same messages identified in this article, but they also include income-eligibility information.

Another recent health-coverage-marketing campaign was launched to promote New York's Disaster Relief Medicaid—a four-month program created in response to a damaged computer system in the wake of the September 11, 2001, attacks.[12] While this program was not just for children (in fact, childless adults could qualify), it provides insights into the successful marketing of public health programs. Effective ads and strong word of mouth conveyed to uninsured and low-income New Yorkers that applying for this public health insurance program was quick and easy, that income-eligibility levels were higher than for other programs ("anybody could qualify"), and that coverage was free.[13] As a result, an unprecedented 380,000 people were enrolled.[14]

These initiatives, as well as state marketing of SCHIP and Medicaid, illustrate the effectiveness of health coverage marketing. At the same time, creating attractive and compelling ads is only part of the solution. States need to create an accessible enrollment process to enable families to successfully enroll their children. The enrollment process has traditionally been a significant barrier to Medicaid enrollment and has been cited as a reason why families do not enroll or do not complete the process (see the article by Cohen Ross and Hill). Indeed, states risk losing interested parents if their enrollment processes are not as simple as their ads imply. Pairing an effective marketing campaign with a streamlined enrollment process holds the most promise for ensuring that all eligible children can obtain health coverage.

Much of the content of this article was drawn from a report that was co-written by Michael Perry, and Vernon Smith and Catherine Smith of Health Management Associates, under the guidance of Barbara Lyons, Deputy Director of the Kaiser Commission on Medicaid and the Uninsured.

ENDNOTES

1. Kaiser Commission on Medicaid and the Uninsured. *Marketing Medicaid and CHIP: A study of state advertising campaigns*. Washington, DC: KCMU, October 2000.
2. Calls were made to either Medicaid or SCHIP directors, or SCHIP outreach coordinators, in 50 states and the District of Columbia. Nonresponding states included Louisiana, New Hampshire, and South Dakota.
3. Because this study was conducted in the summer of 2000, it describes state advertising and marketing efforts that primarily occurred in 1998 and 1999. Therefore, current marketing efforts by states and others to promote public health programs for children are not fully addressed in this article. Nonetheless, most state-sponsored advertising occurred during the time of the study, when SCHIP was new and states wanted to raise awareness about the program.
4. Among the 48 states studied, roughly equal numbers implemented SCHIP as a Medicaid expansion (16 states), separate program (14 states), or combination plan (18 states).
5. A few states reached out to former welfare beneficiaries. Their SCHIP and Medicaid ads pointed out that if parents had just left welfare, their children might still be eligible for SCHIP or Medicaid.
6. A few states acknowledged the central role that grandparents often play in children's lives by creating ads that featured photos of grandparents with their young grandchildren.
7. Kaiser Commission on Medicaid and the Uninsured. *Medicaid and children: Overcoming barriers to enrollment*. Washington, DC: KCMU, January 2000.
8. Methods for evaluating effectiveness included tracking the volume of calls or applications coming in, asking callers to call an 800 number and report where or how they learned of the programs, asking applicants how they heard about the programs on written applications, and surveying program enrollees.
9. Richardson, D., Statler, J., and Giles, M. *Addressing the barriers to covering kids: A values based framework*. Reston, VA: Wirthlin Worldwide, 2001.
10. Ryan, J.M. *SCHIP turns five: Taking stock, moving ahead*. National Health Policy Forum Issue Brief No. 781. Washington, DC: NHPF, August 15, 2002.
11. For more information on the Robert Wood Johnson initiative, see http://www.coveringkids.org/.
12. Perry, M. *New York's Disaster Relief Medicaid: Insights and implications for covering low-income people*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured and the United Hospital Fund, August 2002.
13. See note 12, Perry.
14. City of New York Human Resources Administration. The Official New York City Web Site. Accessed at www.nyc.gov/html/hra/news_press03_12.html.

Appendix 1

How States Are Promoting Children's Health Coverage Programs

State	Type of CHIP Program	Promote Medicaid and CHIP Jointly or Separately	Name of Medicaid Program	Name of CHIP Program
Alabama	Combination	Separately	Medicaid	ALL KIDS
Alaska	Medicaid	Jointly	Denali KidCare	Denali KidCare
Arizona	Separate	Jointly	Arizona Health Care Cost Containment System	KidsCare
Arkansas	Medicaid	Jointly	ARKids	ARKids
California	Combination	Jointly	Medi-Cal for Children	Healthy Families
Colorado	Separate	CHIP only	Baby Care/Kids Care	Child Health Plan Plus (CHP+)
Connecticut	Combination	Jointly	Husky A	Husky B
Delaware	Separate	Jointly	Diamond State Health Plan	DE Healthy Children Program
District of Columbia	Medicaid	Separately	Medicaid	DC Healthy Families
Florida	Combination	Jointly	Florida KidCare	Florida KidCare
Georgia	Separate	Separately	Medicaid	PeachCare for Kids
Hawaii	Medicaid	Jointly	QUEST	QUEST
Idaho	Medicaid	Jointly	CHIP	CHIP
Illinois	Combination	Jointly	KidCare	KidCare
Indiana	Combination	Jointly	Hoosier Healthwise Package A	Hoosier Healthwise Package C
Iowa	Combination	CHIP only	Medicaid	HAWK-I
Kansas	Separate	Separately	PrimeCare and HealthConnect	Health Wave
Kentucky	Medicaid	Jointly	K-CHIP	K-CHIP
Louisiana	*No response*			
Maine	Combination	Jointly	Medicaid	CubCare
Maryland	Medicaid	Separately	Medicaid	Maryland Children's Health Program
Massachusetts	Combination	Jointly	MassHealth	MassHealth
Michigan	Combination	Jointly	Healthy Kids	MI-Child
Minnesota	Medicaid	Jointly	Medical Assistance	MinnesotaCare
Mississippi	Combination	Jointly	Mississippi Health Benefit	Mississippi Health Benefit
Missouri	Medicaid	Jointly	MC+	MC+ for Kids
Montana	Separate	CHIP only	Medicaid	Montana CHIP

State	Type of CHIP Program	Promote Medicaid and CHIP Jointly or Separately	Name of Medicaid Program	Name of Separate CHIP Program
Nebraska	Medicaid	Jointly	Kids Connections	Kids Connections
Nevada	Separate	Jointly	Medicaid	Nevada CheckUp
New Hampshire	*No response*			
New Jersey	Combination	CHIP only	Medicaid	New Jersey KidCare
New Mexico	Medicaid	Jointly	NewMexiKids	NewMexiKids
New York	Combination	Jointly	Growing Up Healthy	Child Health Plus (state-funded)
North Carolina	Separate	Jointly	HealthCheck	NC HealthChoice for Children
North Dakota	Combination	Jointly	Phase I - Healthy Steps	Phase II - Healthy Steps
Ohio	Medicaid	Jointly	Healthy Start	Healthy Start
Oklahoma	Medicaid	Jointly	SoonerCare	SoonerCare
Oregon	Separate	Jointly	Oregon Health Plan	CHIP
Pennsylvania	Separate	Separately	Medical Assistance/Medicaid	CHIP
Rhode Island	Combination	Jointly	Rite Care	Rite Care
South Carolina	Medicaid	Jointly	Partners for Healthy Children	Partners for Healthy Children
South Dakota	*No response*			
Tennessee	Medicaid	Jointly	TennCare for Children Initiative	TennCare for Children Initiative
Texas	Combination	Jointly	TexCare Partnership	TexCare Partnership
Utah	Separate	CHIP only	Medicaid	CHIP
Vermont	Medicaid	Jointly	Dr. Dynasaur	Dr. Dynasaur
Virginia	Separate	CHIP only	Medicaid	Children's Medical Security Insurance Program
Washington	Separate	Jointly	Healthy Kids Now!	Healthy Kids Now!
West Virginia	Combination	Jointly	WV CHIP - Phase I	WV CHIP - Phase II
Wisconsin	Combination	Separately	Medicaid	BadgerCare
Wyoming	Separate	Jointly	Medicaid for Children	Wyoming Kid Care
Total Responding: 48	**Medicaid: 16** **Separate: 14** **Combination: 18**	**Jointly: 35** **Separately: 7** **CHIP only: 6**	**Medicaid/Medical Assistance: 15** **New CHIP name: 41** **Same name for Medicaid & CHIP: 23**	

Note: Some states use different names for their Medicaid managed care programs, which may not be listed above.

Source: Perry, M., Lyons, B., and Smith, V. *Marketing Medicaid and CHIP: A study of state advertising campaigns.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2000.

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Balancing Efficiency and Equity in the Design of Coverage Expansions for Children

Linda J. Blumberg

An important challenge in designing policy initiatives to address the problem of uninsured children is that the objectives implicit in the programs can conflict. These conflicts necessitate prioritizing multiple objectives and identifying acceptable tradeoffs in order to achieve effective policy design that reflects the nation's social priorities. This article provides a general discussion of some competing objectives and tradeoffs and presents a framework for evaluating future attempts to design children's health insurance programs.

The Objectives of Reform

While expanding coverage is the focus of insurance programs for children, financial constraints combined with a general desire for fairness in program implementation complicate the particular elements of a health insurance initiative. Reforms to expand children's coverage reflect the tradeoffs between two main objectives: target efficiency (directing as many program dollars as possible to currently uninsured children) and horizontal equity (treating children in similar circumstances alike).

Target Efficiency

Given financial constraints, many policymakers hope to direct as many designated program dollars as possible to currently uninsured children, thereby achieving the greatest possible health insurance coverage "bang for the buck." This objective is known as target efficiency.[1] The intent is to minimize the government dollars spent on children who would have been insured without a new program. Undesired spending on children who could obtain health insurance elsewhere is often referred to as "crowd-out" in the health policy literature, since government spending is considered to be crowding out private spending on health insurance. In other words, the underlying premise is that government should not pay for children's health insurance if parents can afford to buy it in the private market.

Political motivations also influence policy preferences for target efficiency. Policymakers recognize that new programs will be judged by their measurable effects, particularly by how much they increase the number of insured individuals. A calculation frequently used to analyze new and proposed programs is the federal cost per newly insured person—a measure wholly designed to capture a program's target efficiency. Although other measures may seem equally important in determining program success—such as stability of coverage, quality of care received, or improved

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financial situation among families who no longer have to pay for coverage they find difficult to afford—these types of gains are more difficult to measure quantitatively. As a consequence of needing to demonstrate measurable improvements from a new program to justify additional spending, policymakers place a greater emphasis on designing programs that will substantially increase the number of insured children.

Horizontal Equity

A second policy objective, horizontal equity, focuses on treating children in similar circumstances alike. This objective is consistent with the desire for fundamental fairness—for example, that all children in families with the same incomes have the same program eligibility status.[2] Beyond simple fairness, however, a program designed to achieve horizontal equity avoids creating perverse incentives. For example, assume that subsidies for a new insurance program for children are limited to children without previous insurance coverage. In such a case, two children could have the same family income and live in the same area, but if one child's parents purchase employer-based insurance coverage for the child, she is no longer eligible for public coverage. If the other child's parents have not purchased insurance for him, then that child remains eligible. Parents would have a new incentive to keep their children uninsured for the required length of time—an undesirable policy effect by anyone's calculation. While there is no evidence on the extent to which such incentives actually lead to this type of undesired response, the incentive still exists.

Another example of undesired incentives created by inequities in policy treatment would be if program eligibility were limited to children of workers (or workers themselves, for that matter) whose employers did not offer private group health insurance. In such a case, workers whose incomes were low enough to qualify for the program would have an incentive to find a job that did not offer employer-sponsored health insurance, even if that job might not be the best fit for their skills. In other words, the effect of the policy on job choice could lead to inefficiencies in the job market.

Workers might make such a choice for a number of reasons. If they enrolled their children in the public plan, workers would save the out-of-pocket contributions to premiums that most employer plans require. These premium contribution requirements are often substantial relative to the small (or even zero) premium contributions that are required for public coverage. In addition, public insurance benefit packages tend to be more generous than packages through private employer plans, so an individual could save substantially on cost sharing (deductibles and coinsurance) through a public plan. Research evidence also suggests that workers pay for a significant share of their employers' contributions to employer-sponsored health insurance policies through lower wages than they would have if insurance were not offered. Such a phenomenon implies that workers would also experience a wage increase as a consequence of moving from an insurance-offering to a non-insurance-offering employer. This further strengthens a worker's incentive to seek a non-offering employer if insurance coverage for family members would be available through a public program.[3]

Similarly, when eligibility for subsidies or programs depends on employer behavior, employers may change their own behavior in disadvantageous ways. Take the previous example, in which workers and family members would be eligible for a new public insurance program only if their employer did not offer group coverage. Consider a hypothetical employer who offers employer-sponsored health insurance to her workers. If enough workers would be eligible for public insurance if their employer did not offer private insurance, the workers would have the same incentives described previously to persuade their employer to stop offering coverage. If the employer did stop offering coverage, those eligible for the new program could enroll in public coverage, but there would likely be others working for the same employer who would not be income eligible for public coverage. These workers and their families who are not eligible for public

. . . the objectives of target efficiency and horizontal equity cannot be perfectly met simultaneously.

coverage and who have just lost their employers' offer of insurance would have to seek coverage on their own. Consequently, a policy that limited public program eligibility to those without employer offers could lead to a reduction in the employer offer rate and could also potentially leave some families without insurance.[4] An alternative approach would be to subsidize the purchase of employer-sponsored health insurance coverage for low-income children, a policy that could ameliorate the types of perverse incentives described here. (See the article by Curtis and Neuschler in this journal issue.)

The Conflict between Target Efficiency and Horizontal Equity

The dilemma when designing policy initiatives to increase children's health insurance coverage is that the objectives of target efficiency and horizontal equity cannot be perfectly met simultaneously. Prioritizing target efficiency by designing a program that narrowly defines eligible populations as particular pockets of the uninsured prioritizes target efficiency but results in inequities, which was the case in the example of the two children, one with and one without employer-based coverage. The highly targeted program rules reward only the parents who have not made the financial effort to insure their child. Another potential inequity could occur if the benefit package available through a public program were more generous than the package through a privately purchased policy.

Conversely, if horizontal equity were prioritized, fewer uninsured children could be covered within a given budget. In the example used above, a policymaker focusing on horizontal equity might design a program to make all children in families with incomes below some percentage of the federal poverty level (FPL) eligible for fully subsidized health insurance coverage, regardless of prior insurance status. This design would solve the equity concerns, but the program would cost more than a carefully targeted program because more children would be eligible. In addition, a significant share of the children eligible for the program may have had prior insurance coverage, thereby reducing the apparent target efficiency of the program.

Of course, how well a program achieves target efficiency depends on how the target population is defined. If the target population is defined as uninsured children below a certain percentage of the FPL, then it would be considerably more difficult to achieve both target efficiency and horizontal equity than if the target population is defined as all children below a certain percentage of poverty. The first definition is more closely associated with the idea of generating as much new insurance coverage as possible for a given budget. The latter, however, is more consistent with the notion that even low-income children with private insurance are vulnerable to losing their coverage, and public policy ought to provide a stable source of insurance regardless of current status.

Carefully defining the target population by income can improve policymakers' ability to balance target efficiency and horizontal equity. As Table 1 illustrates, children in families with income levels typically associated with the Medicaid program (that is, usually under 100% of the FPL), are less likely to have employer-sponsored health insurance than are higher-income children. If all children in the lowest income ranges with low levels of private insurance coverage were made eligible for a public insurance program, then displacement of previous insurance would not be of great concern and all children at that income level could be treated the same. However, children in the higher income groups, including those typically associated with the State Children's Health Insurance Program (SCHIP) program (that is, usually from families at 100% to 200% of the FPL, as detailed in the article by Wysen, Pernice, and Riley in this journal issue), are more likely to have employer sponsored health insurance. As a result, the balance between horizontal equity and target efficiency becomes more and more difficult as policymakers attempt to design mechanisms for reaching the higher-income uninsured.

Different Approaches to Prioritizing Efficiency and Equity

Medicaid and SCHIP have taken different approaches to prioritizing the competing objectives of target efficiency and horizontal equity. The Medicaid program for chil-

Table 1

Distribution of Coverage for Children (Ages 0 to 18) by Family Income Relative to the Federal Poverty Level

Family income relative to the FPL	Employer-sponsored health insurance	Medicaid, SCHIP	Other public insurance[a]	Private nongroup insurance	No insurance
Less than 100%	21.6%	47.8%	1.4%	3.4%	25.8%
100%–149%	44.6%	31.4%	1.8%	3.4%	18.8%
150%–199%	63.3%	16.2%	2.3%	4.1%	14.0%
200%–299%	76.6%	6.5%	1.9%	4.9%	10.1%
300%–399%	86.6%	2.7%	1.1%	4.2%	5.4%
400% and over	91.0%	0.7%	0.9%	3.9%	2.8%[b]

[a] Includes Medicare, Champus, and other federal programs.
[b] Columns may not add precisely to 100% due to rounding.

Source: Tabulations of the March 2001 Current Population Survey. Washington, DC: Urban Institute.

dren originally limited eligibility to those with extremely low incomes; it was target efficient but had serious equity problems. Over its history, however, the Medicaid program has evolved to an approach that better balances the two goals. SCHIP has focused most explicitly on target efficiency. The approaches of the two programs are discussed in detail below.

Medicaid

Until the mid-1980s, Medicaid eligibility for children focused on children in families whose income and family structure qualified them for cash assistance through Aid to Families with Dependent Children (AFDC). AFDC was the precursor to the current welfare program, Temporary Assistance for Needy Families (TANF).[5] Because AFDC income-eligibility levels varied considerably by state, this approach engendered interstate equity issues: Children with the same family incomes living in different states were treated differently.[6] In addition, children in two-parent families had considerably more difficulty qualifying for Medicaid coverage, because the AFDC eligibility rules favored single-parent families. Enrollment in Medicaid was not conditioned on prior insurance status, and participation among the AFDC eligible population was high.[7]

As the Medicaid program evolved in the late 1980s and the 1990s, eligibility rules for children became more disconnected from eligibility for AFDC. For example, states were required to expand coverage to children in two-parent families and to those with higher family incomes.[8] As of April 1990, all state Medicaid programs were required to phase in coverage for children up to age six in families with incomes up to 133% of the FPL. Children born after September 30, 1983, in families with incomes up to 100% of the FPL were eligible starting in July 1991. States could also choose to cover infants in families with incomes up to 185% of the FPL.

The expansions in eligibility do focus on low-income children, many of whom do not have access to employer-sponsored health insurance, thereby increasing target efficiency. The more a program includes children with a low probability of having private health insurance without government assistance (that is, lower-income chil-

dren), the more target efficient the program is. While analyses differ as to how much Medicaid expansions simply displaced, or crowded out, private coverage,[9] researchers generally agree that at least 80% of the children enrolled because of the expansions would not otherwise have had insurance.[10]

The changes to the Medicaid program increased interstate equity by providing a federal minimum-income eligibility threshold for children in all states. In addition, now that the expansions are fully phased in, inequities across children of different ages within a state have been reduced. All children under age 18 in families with incomes up to 100% of the FPL are now eligible. Variations in eligibility criteria persist, however, as some states exceed minimum standards while others do not. (See article by Wysen, Pernice, and Riley.)

Consequently, the Medicaid expansions for children appear to have struck a balance with reasonable levels of target efficiency and improvements in horizontal equity. Participation levels for the program may have been adversely affected, however, by a narrow targeting of the expansion program to children that generally excluded their parents.[11] In addition, administrative barriers such as lack of familiarity with eligibility rules and onerous application procedures have probably contributed to lower-than-desired participation rates.

SCHIP

Target efficiency was a high political priority among those who drafted the SCHIP legislation.[12] Because income-eligibility levels for SCHIP are higher than those for the traditional Medicaid program, policymakers worked to avoid spending federal dollars largely on those who would have had private insurance without the new program. This goal was explicitly laid out in the legislation, with eligibility for SCHIP limited to uninsured children.[13] In contrast, eligibility under Medicaid is not based on a child's insurance status. States that have chosen to expand Medicaid under SCHIP cannot exclude children according to prior insurance status (unless they receive a waiver to do so), while SCHIP programs that are run as independent programs must have some type of strategy in place to prevent crowd-out.[14]

States placing different emphases on these mechanisms are likely to have varying success with excluding the previously uninsured.[15] Little evidence currently exists regarding what works to minimize crowd-out and what does not. One finding is that many states have lower participation rates in their SCHIP programs than in their Medicaid programs.[16] These rates are probably partly due to the newness of the SCHIP programs, both because it takes time to educate people that programs exist and because enrollment processes often do not run smoothly in the early implementation stage. But another contributing factor may be administrative barriers designed to exclude those with prior coverage. Such administrative mechanisms can discourage not only the privately insured, but all potential applicants.[17]

SCHIP was designed to provide considerable flexibility to the states, even if some inequities result. Program eligibility rules as well as administrative choices vary considerably across the states because of differences in political preferences, in ability to finance coverage expansions, and in the generosity of the Medicaid programs from which each SCHIP builds.[18] However, significant differences in generosity of programs across states have resulted.

In addition, the federal matching rate for SCHIP-eligible children is higher than the rate for Medicaid-eligible children, which could contribute to horizontal inequities. State governments receive higher federal payments for enrolling SCHIP-eligible children than for enrolling Medicaid-eligible children, even though the SCHIP children come from higher-income families than do Medicaid children. Consequently, states seeking to reduce the number of uninsured children have a greater incentive to enroll children in SCHIP than in a Medicaid program. Although current evidence on participation rates does not seem to indicate that states favor SCHIP enrollment over Medicaid enrollment,[19] the incentive to do so over time is troubling. If states do in fact begin to sacrifice resources from Medicaid outreach and enrollment in order to increase resources allocated to SCHIP outreach and enrollment, this could lead to a redistribution of public spending from lower-income to somewhat higher-income children.

At the same time, some aspects of SCHIP contribute to improved horizontal equity. For example, the higher federal matching rates that the federal government provides to participating states for SCHIP have allowed states with fewer resources to finance more generous expansions

than they would have otherwise been able or willing to do under the Medicaid matching rates. This boost to the more financially constrained states, combined with limits as to how high up the income scale states could subsidize children while still receiving federal matching funds, means that the SCHIP program is likely to improve interstate equity somewhat.[20]

Some states have also used their flexibility to expand public insurance program eligibility to the parents of Medicaid- and SCHIP-eligible children. Early results suggest that states that include parents are increasing the participation rates of their children.[21] Such expansions increase horizontal equity by removing differential treatment by age, but with reduced target efficiency. The added benefit of expansions to parents is that the initial child target population is reached more effectively.[22]

Overall, SCHIP has placed a greater emphasis on target efficiency than on horizontal equity. Policymakers, recognizing that children between 100% and 200% of the FPL had employer-sponsored health insurance, attempted to legislate the exclusion of those with prior coverage and thus increase target efficiency. Achieving target efficiency within this higher-income group of children is clearly more difficult than within the lower-income Medicaid population. Families eligible for Medicaid are less likely to have employer-sponsored coverage, and thus exclusion mechanisms are less relevant. In the future, as the SCHIP program matures and more effort is made to increase participation rates, the focus on horizontal equity issues may also increase.

Ways to Improve the Balance between Efficiency and Equity

The previous discussion highlights that target efficiency and horizontal equity cannot be perfectly satisfied simultaneously. Both objectives have political and social value, and neither should be ignored. Policymakers should strive to design future programs to better balance these two objectives. Several possible approaches could be tried separately or in combination.

For example, one possible approach would be to define eligible populations very narrowly, and expand coverage incrementally. All children within a small subpopulation (defined, for example, by narrow bands of family income relative to poverty) could be treated equally, thereby limiting costs. The drawback to this approach would be that it requires accepting a slower path to coverage expansion. The benefits would be that it would be viewed as fair, costs would be contained, and program effects could be evaluated prior to widespread implementation.

A second approach to improving the balance between efficiency and equity would be to narrowly define the subsidy or the insurance product being provided. For example, the benefit package of a public insurance product could be limited relative to existing public packages. This approach could lower government spending per enrollee and reduce the attractiveness of the program to those with more generous prior coverage. The challenge would be to carefully tailor a narrow package while retaining significant benefits. Similarly, limited subsidy dollars could be provided to make more children eligible, with each child receiving less assistance.

A third approach would be to design programs to limit eligibility to those receiving coverage through the most efficient sources of coverage and/or providers, such as the most cost-effective managed care organizations or hospitals with the most effective internal utilization controls mechanisms. Such a plan might limit participation significantly among those who already have strong attachments to their providers (those likely to be insured), while reducing program costs.

In the end, policymakers must think realistically: Programs cannot substantially increase coverage, keep costs low, and treat similar individuals the same. In addition, policymakers must determine how much displacement of private insurance spending is acceptable. To make significant progress in reducing the number of uninsured children, policymakers need flexibility in spending public dollars in an increased effort to enroll and retain the many currently eligible, but not enrolled, children. Overemphasis on target efficiency and other administrative barriers have likely hampered these efforts to date. However, target efficiency with little increase in coverage of children is not a satisfying programmatic outcome from anyone's perspective. Future policies need to tip the scales further in the direction of equity in an effort to boost overall participation.

ENDNOTES

1. Blumberg, L.J., Dubay, L., and Norton, S.A. Did the Medicaid expansions for children displace private insurance? An analysis using the SIPP. *Journal of Health Economics* (January 2000) 19(1):33–60.

2. See note 1, Blumberg, et al.

3. Blumberg, L.J. Who pays for employer sponsored health insurance? *Health Affairs* (1999) 18(6):58–61.

4. These types of effects, resulting from altered financial incentives, have been simulated in models by the author and her colleagues. Depending upon the size and structure of a subsidy, they can be significant.

5. Congressional Research Service. *Medicaid source book: Background data and analysis: 1993 update*. U.S. Government Printing Office, January 1993.

6. Because the federal government and the states jointly finance Medicaid and SCHIP, each state has some flexibility to tailor programs to meet the specific needs and fiscal capacity of the state. (The federal government has placed various limits on this flexibility over time and across programs, however, such as maximum-income eligibility thresholds and minimum benefit package requirements.) Consequently, eligibility rules and benefit packages vary across states—that is, opportunities for insurance coverage may be quite different for similar children living in different states. A state may have lower program eligibility levels than average because political preferences for public insurance may be limited or because the formulas used to calculate cost sharing with the federal government may not be adequately adjusted for a state's relative ability to finance insurance for its low-income population. Income and the costs of living vary among states, making strict comparisons of interstate equity difficult.

7. Dubay, L., Kenney, G., and Haley, J. Children's participation in Medicaid and SCHIP: Early in the SCHIP Era, *Assessing the New Federalism*, Series B. Washington, DC: Urban Institute, 2002. New Federalism: National Survey of America's Families, Series B, no. B-40, March 2002, pp. 1–7.

8. See note 5, Congressional Research Service.

9. Dubay, L. Expanding public insurance coverage and crowd-out: A review of the evidence. In *Options for expanding health insurance coverage: What difference do different approaches make?* J. Feder, and S. Burke, eds. Washington, DC: Henry J. Kaiser Family Foundation, 1999, pp. 1–17.

10. Cutler, D.M., and Gruber, J. Does public insurance crowd-out private insurance? *Quarterly Journal of Economics* (1996) 11(2):391–430; Dubay, L.C., and Kenney, G.M. Revisiting the issues: The effect of Medicaid expansions on insurance coverage of children. *The Future of Children* (Spring 1996) 6(1):152–61; Dubay, L.C., and Kenney, G.M. Did the Medicaid expansions for pregnant women crowd-out private insurance? *Health Affairs* (January/February 1997) 16(1):185–93; Cutler, D.M., and Gruber, J.G. Medicaid and private insurance: Evidence and implications. *Health Affairs* (January/February 1997) 16(1):194–200; See note 1, Blumberg, et al; Yazici, E., and Kaestner, R.J. Medicaid expansions and the crowding out of private health insurance among children. *Inquiry* (2000) 37(1).

11. A pregnant parent is the exception. See note 7, Dubay, et al.

12. Lutzky, A.W., and Hill, I. Has the jury reached a verdict? States' early experiences with crowd out under SCHIP. *Assessing the New Federalism*. No. 46. Washington, DC: Urban Institute, June 2001. See notes 16 and 18. Occasional Paper No. 47, pp. 1–24.

13. The Balanced Budget Act of 1997, Public Law 105–33.

14. See note 12, Lutzky and Hill.

15. See note 12, Lutzky and Hill.

16. See note 7, Dubay, et al.

17. See note 9, Dubay.

18. Ullman, F., Hill, I., and Ameida, R. CHIP: A look at emerging state programs. *New Federalism: Issues and options for states*, Policy Brief A-35. Washington, DC: Urban Institute, September 1999, pp. 1–5.

19. See note 18, Ullman, et al.

20. While higher matching rates surely make it easier for all states to do more expansions of coverage than they would otherwise, it is worth noting that, in many cases, higher-income states received larger increases in absolute dollars than did lower-income states under SCHIP. So while equity from the beneficiaries' perspective was likely improved, this is not necessarily the case from the perspective of state governments.

21. See note 7, Dubay, et al.

22. See note 7, Dubay, et al.

Creative Solutions

EDITOR'S INTRODUCTION

The "Creative Solutions" section features four articles that focus on innovative efforts to address a variety of shortcomings in current public programs to provide health coverage to low-income children. In general, the programs highlighted here strive to address gaps in coverage, streamline enrollment procedures, and create more cohesive systems.

The article by Curtis and Neuschler explores ways to help working parents who cannot afford to insure their children, even when their employers offer health coverage. The article discusses the benefits and obstacles to linking public and private employer benefits through subsidies known as premium assistance, and describes the experiences of some states that have these programs.

Two articles describe potentially complementary efforts to streamline enrollment. As Horner, Lazarus, and Morrow detail, an express lane eligibility (ELE) strategy would enable families whose children participate in other safety net programs (for example, the National School Lunch program) to sign up simultaneously for all the programs for which they are eligible. The next article by Klein explains how a presumptive eligibility (PE) strategy would use the information from a family's application in one program to determine whether the child is eligible for another program, but would automatically assume that the child was eligible until proven otherwise. In addition, children could start using benefits while their application was being processed. Both ELE and PE would move enrollment into the communities to make the process more convenient and less intimidating for families.

Finally, the fourth article by Wong details two county-level initiatives to expand insurance coverage for children who do not meet state eligibility criteria. Santa Clara County, California, has developed an insurance expansion model, while King County, Washington, is using a service coordination model to provide children with a regular source of care. The article describes the approach each county has taken, the similarities and differences between the two, and lessons for other counties that want to create similar initiatives.

These four articles illustrate the opportunities and challenges facing those who are trying to expand and improve health coverage for America's low-income children.

Premium Assistance

Richard E. Curtis and Edward Neuschler

Many low-income, uninsured children have access to employer coverage but are not enrolled, presumably because their parents cannot afford to enroll them. One strategy for increasing the enrollment of low-income children is to help parents pay the employee contribution required for family enrollment in their employment-based health insurance. This strategy is known as "premium assistance."

Premium assistance offers many potential benefits as a means for providing coverage to low-income children; but at the same time, several practical difficulties in realizing that potential remain.

Premium-Assistance Strategies Hold Promise for Many Children

Premium assistance is a promising strategy for providing coverage to children in low-income families with access to employer-provided coverage. As shown in Table 1, an estimated 55% of uninsured children in families with incomes between 133% and 200% of the federal poverty level (FPL) have access to employer coverage. Furthermore, public health insurance programs for children already authorize this type of assistance[1] and can help any eligible persons pay the premiums required to enroll in any private health insurance that is available to them. This approach is particularly cost effective for employment-based insurance because employers already pay a sizable share of the total premium. Overall, as this section details, premium assistance has the potential to cover more children with available public dollars, provide coverage to whole families, and help prevent "crowd-out" (that is, replacing or substituting for existing employer coverage) by complementing rather than replacing employer contributions.

Making Public Dollars Go Farther

Because employers typically pay about 70% to 75% of the cost of family coverage,[2] subsidizing workers' share of premiums to enroll their children as well as themselves in employer coverage can be less expensive than providing direct coverage, especially family coverage, under the State Children's Health Insurance Program (SCHIP) or Medicaid. For example, Rhode Island saves an average of $178 per month for every family enrolled in its RIte Share premium-assistance program rather than in its regular RIte Care (Medicaid and SCHIP) managed care program.[3]

Providing Coverage for Children and Families

Providing whole family coverage, either directly or through premium assistance, also benefits children by making it more likely that they will get needed care. Studies show that children are more likely to use care if their parents do, an effect that is even stronger if both parent and child are insured.[4] For example, in states that have expanded coverage for parents under Medicaid, 81% of eligible children participate in Medicaid, compared to only 57% of children in states without family-based coverage programs.[5] Moreover, states such as Wisconsin, Rhode Island, and New Jersey have

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Table 1

Children with Employer Coverage and Uninsured, by Family Income Relative to Poverty

Family Income Relative to Federal Poverty Level	Among Children, Percent with Employer Coverage, 1999[a]	Among Children, Percent Uninsured, 1999[a]	Ratio of Children with Employer Coverage to Uninsured Children, 1999[a]	Percent of Uninsured Children Eligible for Employer Coverage through a Parent, December 1996[b]
Less than 100%	17.8%	27.1%	0.7:1	23%
100%–132%	41.4%	20.6%	2.0:1	40%
133%–199%	58.4%	19.7%	3.0:1	55%
200%–249%	72.7%	13.3%	5.0:1	62%
250%–399%	84.4%	8.0%	10.5:1	51%
400% and over	90.8%	4.5%	20.0:1	28%

[a]March 2000 Current Population Survey.
[b]1996 Medical Expenditure Panel Survey (full-year panel).

Source: Institute for Health Policy Solutions

demonstrated that offering health insurance coverage for whole families is a more effective way to reach uninsured children than covering only children under SCHIP. For example, the number of children enrolled in Rhode Island's RIte Care program grew only 10% between December 1995 and December 1998. After coverage was expanded to parents (in November 1998), the number of children enrolled grew 47% over the next three years (ending in December 2001).[6]

Overall, because employer contributions for family coverage can greatly reduce the net cost of public subsidies needed, and because coverage through work is an attractive coverage venue for many working parents, subsidizing enrollment in employment-based family coverage can be a cost-effective way for states to provide coverage to entire low-income families.

Helping Prevent "Crowd-Out"

Using public dollars to offer premium assistance to low-income working families could cover more families at lower cost by complementing rather than replacing employer contributions. While greatly beneficial, public-program expansions that include parents as well as children may pose a greater risk of "crowding out" existing employer coverage when eligibility is extended above the FPL. Crowd-out is more likely above the FPL because private employment-based coverage is widespread among non-poor but low-income working families. For example, in families with incomes between 133% and 200% of the FPL, three times as many children had employer coverage as were uninsured in 1999 (see Table 1).[7]

Recent research indicates that a significant share of new public coverage for adults above the FPL replaces private (employment-based) coverage.[8] These findings suggest that virtually free public coverage induces many low- and modest-income families (and/or their employers) to drop existing employer coverage, which costs an average of almost $8,000 annually in combined employee and employer contributions. For example, after Rhode Island achieved the lowest reported rate of uninsured children in the country (2.4% in 2000),[9] the state's RIte Care program identified a significant shift from employer coverage (see Box 1).[10]

Because of their desire to stretch public funds by capturing available employer contributions, avoiding crowd-out and covering whole families where possible, state and federal officials remain keenly interested in programs that would help low-income families enroll their children in private employment-based insurance when it is available to them.

Challenges to Implementing Premium Assistance

Despite the substantial potential suggested by these data and observations, premium-assistance programs undertaken to date have reached relatively few children in 12 states.[11] The early experience of one of those states, Wisconsin, illustrates both the potential reach of

Box 1

Rhode Island Grapples with "Crowd-Out"

Rhode Island's RIte Care (Medicaid and SCHIP) program initially covered children up to 250% of the FPL. In late 1998, the state expanded the program to include coverage of parents up to 185% of the FPL. This expansion succeeded in covering more children as well as parents. By 2000, the program had reduced the percentage of children without insurance to 2.4% and the overall uninsured rate to 6.2%, the lowest rates in the nation.[a] Total RIte Care enrollment increased by 40% between November 1998 and June 2000, straining the state's budget.[b]

One reason for the explosive program growth was a shifting of low-income families out of employer coverage and into RIte Care, a process known as "crowd-out." The *Providence Journal* reported in May 2000 that as many as 20,000 people—almost 20% of the total program enrollment—may have dropped private health insurance in order to take advantage of the free state program.[c] The largest participating HMO, Neighborhood Health Plan, estimated that one-third of its new RIte Care patients were migrating from private insurance plans.[c] Another carrier experienced 4,200 voluntary disenrollments from its commercial coverage during 1999 that resulted in subsequent enrollment in the same carrier's RIte Care plan, 83% of them within four months after the commercial disenrollment.[d]

To address the problem of crowd-out, in June 2000, Rhode Island enacted a package of reforms that included an aggressive premium-assistance initiative (RIte Share) aimed at placing eligible families into employer coverage. The reforms included a review of the entire RIte Care caseload to identify families who had access to qualifying employer coverage and to enroll them in it, when it was cost effective for the state to do so. As of July 2002, about 2,200 members had been enrolled in RIte Share, with enrollment expected to reach 5,000 by June 30, 2003.[e]

While generally pleased with the program's success, state managers note that shifting costs back to the employer sector is more difficult than avoiding crowd-out in the first place, and they urge other states to initiate premium-assistance policies before expanding public health insurance programs, especially where parents will be covered in addition to their children.[b]

[a] Rhode Island Department of Human Services. Update: RIte Care, member cost sharing, RIte Share. Providence, RI: Hearing of the Joint Committee on Health Care Oversight, April 29, 2002. Slide presentation. Based on Medicaid Research and Evaluation Project; RIte Share Evaluation Studies. U.S. Bureau of the Census, Current Population Surveys 1994–2000 (September estimates).

[b] RIte Care enrollment increased from 74,221 in November 1998 to 104,041 in June 2000. Ferguson, C. Hindsight and foresight: Lessons for getting it RIte. In *Effective coverage expansions for uninsured kids and their working parents: Links to job-based coverage.* Washington, DC: Institute for Health Policy Solutions, May 18, 2001.

[c] Rowland, C. Officials rethinking RIte Care's mission. *Providence Journal.* May 21, 2000, at p. A-01.

[d] Ferretti, S. Hindsight and foresight: Lessons for getting it RIte. In *Effective coverage expansions for uninsured kids and their working parents: Links to job-based coverage.* Washington, DC: Institute for Health Policy Solutions, May 18, 2001.

[e] Leddy, P. Premium assistance: Opportunities and challenges: Implementing Rhode Island's RIte Share program. Philadelphia, PA: 15th Annual State Health Policy Conference of the National Academy for State Health Policy, August 5, 2002. Slide presentation. Also, personal communication with P. Leddy, February 12, 2003.

Box 2

Wisconsin Experiences Both the Promise and Pitfalls of Premium Assistance

Wisconsin's attempt to integrate premium assistance into its SCHIP program, known as BadgerCare, illustrates both the potential reach of premium assistance in a low-income working population and the practical difficulties involved in realizing that potential. BadgerCare covers parents as well as children, but requires that families take advantage of employment-based coverage if it is available to them and cost effective. Roughly half of working BadgerCare applicants have access to health coverage through their employers. But, as of June 30, 2001, less than one-tenth of 1% had actually been enrolled.[a]

There are several reasons for Wisconsin's low rate of enrollment in employer-based coverage. The state's premium-assistance policies—some driven by federal requirements, some chosen by the state—unnecessarily exclude many employer plans from participation. For example, almost one-half of the applicants with access to employer coverage work for self-insured employers,[a] but the state initially decided to exclude self-insured plans from premium assistance in order to simplify and speed program implementation. (State officials have now reversed that decision.)

In addition, when the program first began, only employers who contributed between 60% and 79% of the cost of family coverage qualified, and only 20% of otherwise-qualified employer plans fell in that range.[a] The minimum required employer contribution has now been lowered to 40%.[b]

Wisconsin has also had difficulty getting the necessary information from employers. About 25% to 30% of forms requesting information are never returned, and of those that are, about one-quarter state that the applicant no longer works for that employer (or never did).[a] These problems have significant implications for verifying employment and earnings for the underlying BadgerCare program, not just for its premium-assistance component.

The initial structure of Wisconsin's program discouraged participation in several ways. As Wisconsin wrestles with fiscal problems, it is moving to address some of the key obstacles—for example, by including more employer plans and proposing to require information about their availability at application. With such changes, the potential of premium assistance is more likely to be realized.

[a] Wisconsin Division of Health Care Financing. Unpublished "employer verification of insurance coverage (EVIC)" program statistics obtained from Donald G. Schneider, Chief, Coordination of Benefits Section, July 27, 2001.
[b] Wisconsin Division of Health Care Financing. Personal communication with Donald G. Schneider, Chief, Coordination of Benefits Section, December 20, 2001.

premium assistance in a low-income working population and the practical difficulties involved in realizing that potential (see Box 2).

The next section describes some of the challenges facing states that seek to implement premium-assistance programs, including administrative costs and resource requirements, the difficulty of arranging "wrap-around" coverage, conflicting program policies, and questions of cost-effectiveness.

Administrative Costs and Resource Requirements

Identifying applicants with access to employer coverage and obtaining the information necessary to evaluate that coverage in a timely fashion can involve considerable effort and resources. The state of Iowa, for example, employs 14 full-time staff members to follow up on Medicaid clients identified by local offices as having access to employer coverage.[12]

States must do much of the necessary administrative work because employers do not want to be burdened with modifications to their existing health plan, payroll deduction, and related programs. And neither employers nor their workers want employers involved in ways that would make them privy to family income information. Employers' resistance to playing any administrative role increases when they realize it would increase their benefit costs while typically providing financial assistance and extra benefit coverage only to those workers who

A less fragmented approach that incorporates a broader income range for premium assistance (incorporating both SCHIP and Medicaid income ranges) would be more equitable and broaden the eligible population considerably.

decline to contribute to coverage for their children. Workers who earn the same or less, and sacrifice financially to cover their children, would not benefit.

Difficulty of Arranging "Wraparound" Coverage

Employer-provided health plans generally do not cover every service available under Medicaid or SCHIP and often charge higher co-payments than Medicaid or SCHIP allows. Arranging wraparound or supplemental coverage to fill in these "gaps" in employer coverage is one of the biggest difficulties states face in pursuing premium-assistance programs under SCHIP.

Under Medicaid, a relatively simple solution to this problem already exists. Premium-assistance enrollees can use a traditional Medicaid card to access services not covered by their employer plans and also to avoid co-payments in excess of the Medicaid allowable level. Several states that use this model, including Wisconsin and Iowa, have found that costs tend to be nominal, as most enrollees prefer to simply use their "mainstream" employer benefits.

Separate (non-Medicaid) SCHIP programs, however, generally do not have their own fee-for-service payment capability, which makes this approach to wraparound coverage unavailable to them.[13] Setting up or contracting for a separate claims-payment system solely to provide wraparound coverage for premium-assistance recipients would be prohibitively expensive,[14] and private health plans have not been willing to undertake the responsibility of "filling in" employer-plan coverage, which can vary widely, on an at-risk basis. Contracting with the state's Medicaid program or fiscal agent to provide wraparound coverage for SCHIP premium-assistance recipients is a possible alternative that only one separate SCHIP program—Virginia—has yet used.[15]

Conflicting Policies

While administrative difficulties are an important impediment, conflicting public-program policies—driven by inconsistent federal regulations and confusion about market roles and incentives—have also made it far more difficult to adopt and implement effective state programs.

Inconsistent Federal Regulations

Medicaid and SCHIP represent somewhat different public policy approaches to increasing children's coverage. The resulting differences in federal regulatory requirements between these two programs often preclude states from operating a single, integrated premium-assistance program (see Table 2). Instead, the two programs require inconsistent policies and, in effect, inconsistent communications to employers and working parents. For example, Iowa, which operates a large health-insurance-premium payment program under Medicaid, does not attempt such a program under SCHIP, even though, given the higher incomes involved, a much higher percentage of SCHIP children are likely to be eligible for employer coverage (see Table 1). Similarly, Maryland has attempted, albeit with minimal success to date, a premium-assistance initiative only for children between 200% and 300% of the FPL (eligible for its separate SCHIP program), and not for lower-income children under its much larger Medicaid or Medicaid-model SCHIP programs.[16]

In the world of employer coverage, such a fragmented approach makes no sense. Narrow income-eligibility ranges may make only a very small fraction of workers eligible for premium assistance for themselves and their children and could mean that higher-income workers qualify for premium assistance while lower-income workers in the same firm do not. Such a program would seem disjointed and unfair to parents whose larger family size lowers their income relative to poverty and thereby precludes them from receiving assistance for an employer family plan covering their colleagues. A less fragmented approach that incorporates a broader income range for premium assistance (incorporating both SCHIP and Medicaid income ranges) would be more equitable and broaden the eligible population considerably. (See the article by Blumberg in this journal issue for a discussion of the equity issues involved with designing programs narrowly versus broadly.) Almost three-quarters (73%) of uninsured children with access to employer coverage are in families with incomes below

250% of the FPL, but only one in eight (12.6%) are in the income range from 200% to 249% of the FPL.[17]

Confusing Market Roles and Incentives

Whether or not a worker has access to employer coverage is determined more by the worker's individual wage or salary level than by the family's total income relative to the FPL. Low-wage workers rarely have coverage from their employers, while higher-wage workers are very likely to have employer coverage, even if they are part of a low-income family. For full-time workers with family incomes between 133% and 200% of the

Table 2

Standards Related to Premium Assistance for Employer Coverage under Medicaid and SCHIP

Issue	Medicaid Health Insurance Premium Payment (HIPP)	SCHIP Premium Assistance (PA)	Waiver Possibilities under New Federal Guidance (HIFA)[a]
Are applicants eligible for premium assistance if they already have employer coverage?	Yes.	No. For SCHIP, applicants must be uninsured. For SCHIP premium assistance, applicants must have been without employer coverage for six months.	States could ask to use federal matching funds to subsidize some applicants who are already insured (within budget limits).
What is the minimum employer contribution required to qualify for premium assistance?	None.	State must specify one. No minimum percentage is specified in federal regulations, but in practice the federal government seems to require no less than 30%–40%.	Federal requirement to specify some minimum can be waived.
Must states provide supplemental coverage for services not covered by the employer plan?	Yes. Recipient must have access to all Medicaid-covered services. (Recipient can use traditional Medicaid fee-for-service card.)	Yes, unless the employer plan meets one of the SCHIP benchmarks. (Harder to handle. Most SCHIP programs have no fee-for-service claims-payment capability.)	Waiver guidance allows greater flexibility on benefit requirements for "optional" groups, so supplemental coverage is less likely to be needed.
Must states "fill in" employer-plan cost-sharing amounts that exceed program rules?	Yes. Essentially, no cost sharing is allowed for Medicaid recipients.	Yes. Must meet statutory SCHIP limitations prohibiting any cost sharing for well-child care and limiting other cost sharing to 5% of family income.	Allows greater flexibility. Only the 5-percent-of-income limit on cost sharing for children remains.
Must premium assistance be cost effective (that is, cost less than direct public coverage)?	Yes. (Most states use HIPP only for obviously high-cost cases. A few, such as Iowa, screen all recipients with access to employer coverage.)	Yes. Costs can be compared on a case-by-case basis or on an aggregate basis for the total premium-assistance population.	Requirement is less strict. Aggregate costs for all those covered under premium assistance must not be "significantly higher" than they would be under a public program.

[a] HIFA refers to the Health Insurance Flexibility and Accountability Demonstration Initiative, announced by the federal Centers for Medicare and Medicaid Services in August 2001.

Source: Based on federal rules and regulations governing Medicaid, HIPP, and SCHIP premium-assistance programs (last updated June 25, 2001), and the new HIFA waiver guidance.

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FPL, for example, only 48% of those earning less than $15,000 per year have employer coverage, compared with 83% of those earning between $30,000 and $40,000 per year.[18]

These data suggest that states should consider individual parents' earnings in addition to total family income in designing public-program policies, particularly for programs that cover parents in addition to children. Basing contribution requirements for parents' coverage at least in part on individual earnings, for example, could help prevent crowd-out.[19] A parent's wage level might also be used as a screening tool to identify children who are more likely to have employer coverage available to them and, therefore, to be candidates for premium assistance.

Difficulty in Achieving Cost-Effectiveness if Only Children Are Eligible

Many states extend coverage above poverty only for children, not their parents. For these states, premium assistance is less likely to be a cost-effective alternative to direct public coverage, particularly when both the per-child public-program cost and employer contributions toward family coverage are relatively low.[20] To date, states have authorized premium assistance only when the family's cost to enroll in its employer's plan is less than the state's cost to enroll the children and any other eligible family members directly into a public program. For example, after a thorough study,[21] Colorado decided not to proceed with premium assistance under its SCHIP program for this reason.

An alternative approach may be possible. States could offer to pay up to their public-program cost toward the family's employer-plan premium and give the family the option of making up the difference out of its own pocket. This option might be attractive to parents who would prefer to have all family members enrolled in the same health plan or who simply prefer their employer plan to the public program. Recent revisions in federal SCHIP regulations now permit such a choice.[22]

Overcoming the Challenges: Successful State Programs

The challenges that states face in implementing successful premium-assistance programs are significant but not insurmountable, as the programs in Iowa, Massachusetts, and Rhode Island demonstrate. For example, Iowa and Massachusetts both have large premium-assistance programs. Iowa has more than 8,000 participants,[23] and Massachusetts has more than 10,000.[24] Rhode Island is steadily adding enrollment to its recently initiated RIte Share program and expects to reach 5,000 enrollees by June 2003 (see Box 1).

Several key factors have contributed to the success of the programs. Each of the three states requires applicants to enroll in employer coverage for which they are eligible, if that coverage is cost effective. Each has

found ways to deal with the difficult issue of wraparound coverage. And each tries to minimize the administrative burden on employers.

Requiring Eligible Applicants to Enroll in Employer Coverage

In order to require applicants to enroll in employer coverage, states must first be able to identify which applicants have employer coverage available to them. Iowa solves this problem by requiring all employed Medicaid applicants to obtain wage- and insurance-verification information from their employers as a condition of eligibility. If an applicant is found eligible, and the employer offers health insurance, the local eligibility office forwards the employer information to the central Health Insurance Premium Payment unit, which follows up to obtain detailed information about the benefits and costs of the employer plan. The cost-effectiveness of "buying in" to the employer plan is then determined by a computerized system. If buying in is found to be cost effective, Medicaid participants are directed to enroll in the employer plan at the next opportunity. Participants pay their share of the premium by payroll deduction, and the state sends them a check for the same amount, on the same schedule.[25]

Addressing Wraparound Coverage

In Iowa, Rhode Island, and Wisconsin, premium-assistance participants continue to receive a traditional Medicaid card, which allows them to access services not covered by their employer plans. Under a federal demonstration waiver,[26] Massachusetts, which offers premium assistance under both Medicaid and SCHIP, uses a different approach. Rather than provide services to supplement employer coverage, Massachusetts requires that to qualify for premium assistance, employer plans must cover a specified list of services, called the Basic Benefit Level.[27]

Minimizing the Administrative Burden

Successful premium-assistance programs minimize the administrative burden on employers, particularly with respect to subsidy administration. Rhode Island had little success with its initial approach, which asked employers to receive subsidy payments from the state and reduce the payroll deduction for premium-assistance-eligible workers. In the first year of operation, only about 275 individuals were enrolled in premium assistance. After the state decided, in early 2002, to make subsidy payments directly to families, rather than through their employers, 1,700 individuals were enrolled within six months.[28]

Implications of New Federal Waiver Opportunities for Premium Assistance

States may find it easier to adopt and implement effective policies with new waiver guidance from the federal government. In August 2001, the federal government issued the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative, which offered formal guidance about a potential new use of demonstration waivers.[29] Table 2 highlights the ways in which HIFA waivers could ease federal requirements that often make implementing premium assistance unnecessarily difficult. Primarily, these waivers would allow greater flexibility in how benefit standards and cost-sharing limitations are applied to employer plans. Using HIFA, for example, a state could design consistent policies across Medicaid and SCHIP income boundaries while creating more elegant subsidy and other policies that better fit the world of employment-based family coverage.

Conclusion

As the examples discussed in this article suggest, premium assistance toward employer-based family coverage could provide a sensible coverage source for many low-income children, while helping assure that SCHIP coverage complements the employer coverage system for most non-poor children. Nonetheless, this approach presents challenges. Early program experiences indicate that while obstacles can be overcome, incremental improvements to highly fragmented and administratively burdensome approaches are unlikely to cover many more children.

Alternatively, creative and responsible use of the kind of flexibility offered by the HIFA waiver initiative has the potential to work as a cost-effective coverage vehicle for many children and their families. While balancing competing policy objectives will be difficult, in an environment of budgetary constraints, increased use of premium assistance can constructively link public and employer benefits and help maximize the number of children covered by health insurance.

ENDNOTES

1. Both SCHIP and Medicaid are authorized to use public funds to help eligible families pay premiums for employer-based coverage, rather than provide coverage directly. Usually, premium-assistance recipients pay for their employer coverage by payroll deduction, just as other workers do, and receive a separate payment from the state program to cover their outlay.

2. In 2002, the average employer paid 73% of the cost of full family coverage, which averaged $7,954 per year, or about $663 per month. Workers paid, on average, $174 per month for full family coverage. Kaiser Family Foundation and Health Research and Educational Trust. *Employer health benefits: 2002 annual survey*. Menlo Park, CA: Henry J. Kaiser Family Foundation, and Chicago, IL: Health Research and Educational Trust, 2002.

3. The state pays health plans $450 per month for an average family enrolled in RIte Care. Under the RIte Share premium-assistance program, the state's average monthly contribution to a family's employer-sponsored coverage is $272. Leddy, P. Premium assistance: Opportunities and challenges: Implementing Rhode Island's RIte Share program. Philadelphia, PA: 15th Annual State Health Policy Conference of the National Academy for State Health Policy, August 5, 2002. Slide presentation.

4. The underlying argument is that parents will know how to get care for their children if they are familiar with the health plan, because they use it themselves. See Hanson, K. Is insurance for children enough? The link between parents' and children's health care revisited. *Inquiry* (Fall 1998) 35:294–302.

5. Dubay, L., and Kenney, G. *Covering parents through Medicaid and SCHIP: Potential benefits to low-income parents and children*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2001.

6. Child enrollment in RIte Care grew from 48,884 in December 1995 to 52,046 in December 1998 to 76,379 in December 2001. Leddy, P. Premium assistance: Opportunities and challenges: Implementing Rhode Island's RIte Share program. Philadelphia, PA: 15th Annual State Health Policy Conference of the National Academy for State Health Policy, August 5, 2002. Slide presentation.

7. See also Kaiser Commission on Medicaid and the Uninsured. *Health insurance coverage in America: 2002 data update*. Washington, DC: KCMU, February 2002, Table 2 (based on Urban Institute analysis of data from the March 2001 Current Population Survey).

8. Kronick, R., and Gilmer, T. Insuring low-income adults: Does public coverage crowd out private? *Health Affairs* (January/February 2002) 21(1):225–239. Marquis, M.S., and Long, S.H. Public insurance expansions and crowd-out of private coverage. To be published in *Medical Care*, 2003. In contrast, most studies of Medicaid's expansion of coverage to children up to 133% of the federal poverty level and pregnant women to 185% of the federal poverty level during the late 1980s and early 1990s found only relatively modest crowd-out of employer coverage. For a review of this work, see Dubay, L. *Expansion in public health insurance and crowd out: What the evidence says*. Menlo Park, CA: Henry J. Kaiser Family Foundation, October 1999.

9. Rhode Island Department of Human Services. Update: RIte Care, member cost sharing, RIte Share. Providence, RI: Hearing of the Joint Committee on Health Care Oversight, April 29, 2002. Slide presentation. Based on Medicaid Research and Evaluation Project; RIte Share Evaluation Studies. U.S. Bureau of the Census, Current Population Surveys 1994–2000 (September estimates).

10. Rowland, C. Officials rethinking RIte Care's mission. *Providence Journal*. May 21, 2000, at p. A-01.

11. As of June 2002, 12 states were operating premium-assistance programs. Programs in 4 states (Iowa, Missouri, Pennsylvania, and Texas) were available only to Medicaid recipients. Virginia operated separate programs for Medicaid and SCHIP recipients. Maryland offered premium assistance only under its separate SCHIP program for children between 200% and 300% of the federal poverty level. Illinois offered premium assistance to children, without federal matching funds, as an alternative to enrollment in its SCHIP "KidCare" program. Wisconsin offered premium assistance only to family groups in the SCHIP income range. And 3 states (Massachusetts, New Jersey, and Rhode Island) offered premium assistance to families and children as part of broader demonstration projects encompassing both Medicaid and SCHIP. Finally, using state funds only, Oregon offered premium assistance to any income-eligible adult or child. [State Coverage Initiatives. *State Coverage Matrix*. Updated June 2002. Accessed August 22, 2002. Available online at http://www.statecoverage.net/matrix.htm. Also state Web sites for Illinois (http://www.kidcareillinois.com/html/enrollment.htm) and Oregon (http://www.ipgb.state.or.us/Docs/fhiaphome.htm) and author's personal communication with Kelly Carter, Manager of KidCare Customer Service, Illinois Department of Public Aid, June 6, 2001. For more in-depth information about many of these state programs, see *Effective coverage expansions for uninsured kids and their working parents: Links to job-based coverage*. Washington, DC: Institute for Health Policy Solutions, May 18, 2001.] Most other states operate limited premium-assistance programs only for Medicaid recipients with significant health problems, but these programs serve very few recipients, and little is known about them.

12. Sexton, J. *Overview of the Iowa Health Insurance Premium Payment (HIPP) program*. Washington, DC: Institute for Health Policy Solutions, February 4, 2000. Available online at http://www.ihps.org.

13. Despite the prevalence of managed care in Medicaid, most state Medicaid programs can still pay claims submitted directly by providers on a traditional fee-for-service basis. Separate (and newer) SCHIP programs, by contrast, often do not have direct claims-payment capability. Instead, these programs contract with private health plans to enroll SCHIP eligibles on a capitated basis.

14. Because of the expensive wraparound coverage, Mississippi never implemented premium assistance under its separate SCHIP program after receiving federal approval to do so. State Coverage Initiatives. *State Coverage Matrix: Mississippi*. Updated June 2002. Accessed August 22, 2002. Available online at http://www.statecoverage.net/ms-employer.htm.

15. Nothing prohibits individual SCHIP programs from contracting with their state's Medicaid program or fiscal agent to provide wraparound coverage for SCHIP premium-assistance recipients. To avoid the need for major system modifications that could make such a proposition too expensive, the state would probably have to give SCHIP premium-assistance recipients access to the full Medicaid benefit package and cost-sharing protections. The equity of such an arrangement might be questioned, because it would give premium-assistance recipients greater benefits than other SCHIP participants; but the Medicaid experience with

wraparound coverage suggests that this concern is more theoretical than practical. Political opposition to such an approach might be hard to overcome, however, because opposition to expansion of the Medicaid program was one of the major reasons behind states choosing to implement separate SCHIP programs.

16. Chang, D. Maryland Children's Health Premium Program: Premium assistance challenges and opportunities. Philadelphia, PA: 15th Annual State Health Policy Conference of the National Academy for State Health Policy, August 5, 2002. Slide presentation.

17. Institute for Health Policy Solutions. Unpublished analysis of the 1996 Medical Expenditure Panel Survey (full-year panel).

18. Neuschler, E., and Curtis, R. ***Individual workers' wage levels, total family income relative to poverty, and prevalence of employer coverage***. Washington, DC: Institute for Health Policy Solutions, August 2001, Figure 3.

19. The risk of crowd-out would be great if virtually free public coverage were made available to applicants with low family incomes but relatively high individual wages. Higher-wage workers are very likely to already have employer coverage. For this reason, taking individual parents' wage levels into account, not just total family income, could be a powerful tool in designing policies that would effectively expand coverage of the uninsured rather than simply substitute public coverage for existing employment-based coverage. In particular, requiring a premium contribution (for public-program coverage of an adult) that increased with wage level would make people less likely to drop employer coverage or switch jobs to qualify for publicly financed coverage. See Neuschler, E., and Curtis, R. ***Expanding healthy families to cover parents: Issues and analyses related to employer coverage***. Washington, DC: Institute for Health Policy Solutions, January 2001.

20. The cost-effectiveness of premium assistance is determined by comparing the cost to enroll all family members in the employer plan with the cost to enroll eligible family members in the public program. Under an employer plan, covering only children is not possible. Parents usually must pay for full family coverage in order to cover their children. (Some plans allow workers to cover their children without covering their spouses, for a lower premium, but workers must always be covered.) The public-program cost, on the other hand, varies directly with the number of eligible family members (and, usually, with their ages and genders). If only the children are eligible, the public-program cost will be lower than if all family members are eligible, and, therefore, only employer plans with lower contribution requirements for family coverage will qualify for premium assistance.

21. Schulte, S., Yondorf, B., Howell, L., and Leif and Associates. ***Final report of the Child Health Plan Plus employer buy-in feasibility study***. Denver, CO: Rose Community Foundation, December 2001.

22. The revised SCHIP regulations at 45 CFR 457 560 indicate that states could treat premiums for family coverage as they do coverage of other family members, rather than counting them against the out-of-pocket expenditure limit for children's coverage. Department of Health and Human Services, Health Care Financing Administration. State Child Health; Revisions to the Regulations Implementing the State Children's Health Insurance Program; Final Rule. ***Federal Register*** (June 25, 2001), vol. 66, no. 122, pp. 33810–24. See especially p. 33815. See also Federal Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration). ***Health Insurance Flexibility and Accountability Demonstration Initiative***. August 2001. Available online at http://www.hcfa.gov/medicaid/hifa/default.htm.

23. See note 12. Total HIPP enrollment includes about 5,500 Medicaid eligibles and about 3,000 ineligible family members.

24. Waldman, B. Coverage goals and implementation experience. In ***Effective coverage expansions for uninsured kids and their working parents: Links to job-based coverage***. Washington, DC: Institute for Health Policy Solutions, May 18, 2001. Total premium-assistance enrollment includes about 6,000 program eligibles and more than 4,000 ineligible family members.

25. See note 12. As noted, however, Iowa has not implemented premium assistance under its separate SCHIP program because that program has no mechanism to fill in employer-plan cost sharing or to pay for SCHIP services not covered by the employer plan.

26. This waiver dates from the mid-1990s and was not issued pursuant to the new Health Insurance Flexibility and Accountability Demonstration Initiative.

27. In early 2002, Massachusetts received federal approval to use "secretary-approved coverage" as the "benchmark" for its premium-assistance program, rather than the "largest commercial HMO" benchmark used for its regular SCHIP program. This approval was granted on the basis that the narrower list of services had previously been approved for use in premium assistance under the state's Medicaid demonstration waiver program. Prior to this approval, children could receive premium assistance if their employer plan equaled or exceeded the Basic Benefit Level. But if their employer plan met the SCHIP benchmark (which very few employer plans do), the state was allowed to claim the higher federal SCHIP matching rate. Massachusetts Division of Medical Assistance. Personal communication with Colleen Murphy, assistant general counsel, May 15, 2002.

28. See note 6, Leddy.

29. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. ***Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative***. August 6, 2001. Available online at http://www.cms.hhs.gov/hifa/hifagdc.htm.

Express Lane Eligibility

Dawn Horner, Wendy Lazarus, and Beth Morrow

Although great progress has been made in providing health coverage to low-income children, 9.2 million children remain uninsured. About 6.8 million of these children are eligible for public health insurance coverage.[1] (See the article by Holahan, Dubay, and Kenney in this journal issue.) Many of these uninsured children are enrolled in other public programs for low-income families that have eligibility requirements similar to those for public health insurance programs (Medicaid and the State Children's Health Insurance Program, or SCHIP).[2] Most low-income, uninsured children (63%, or 4.3 million) are concentrated in families that receive benefits through food stamps, the National School Lunch Program, or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).[3] The school lunch program alone reaches 3.7 million uninsured children, representing more than one-half of all low-income, uninsured children in the United States.[4] Therefore, targeting outreach to and simplifying health insurance enrollment for uninsured children enrolled in other public programs is both logical and efficient.

Programs like food stamps, WIC, and school lunch provide an obvious opportunity to link low-income children with health coverage. States could use eligibility information that families have provided to these programs as a basis for enrolling children in public health insurance coverage, but most states have no such system in place. Instead, families usually must visit multiple public agencies and submit duplicative information to each.

This article describes some states' creative strategies to increase children's enrollment in health insurance by connecting Medicaid and SCHIP with other public programs for low-income children and families. These strategies, referred to as "express lane eligibility" (ELE),[5] have the potential to significantly increase the number of low-income children with health insurance. The article begins with an overview of how ELE works, then assesses challenges facing ELE, and closes by offering several recommendations for how states can expand their use of ELE strategies.

Overview of ELE

States have used a variety of strategies to tackle the problem of high rates of uninsurance among children who participate in other public benefit programs. These strategies include targeted outreach, streamlined application processes, and automatic enrollment.

Targeted outreach uses other public programs as referral sources for finding, contacting, and providing application assistance to uninsured children who are eligible for Medicaid and SCHIP. This strategy has been used most widely with the school lunch program. The income-eligibility threshold for school lunch is more restrictive than that of most state public health insur-

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ance programs: To qualify for the school lunch program, children must live in families with incomes at or below 185% of the federal poverty level (FPL). Therefore, children eligible for school lunch often prove eligible for Medicaid or SCHIP as well. One example of targeted outreach through the school lunch program was recently implemented in Ohio (see Box 1).

The strategy of streamlining applications goes a step further than targeted outreach by allowing the information a family has already provided to another public program to be used to evaluate a child's eligibility for Medicaid/SCHIP, or as a basis for recertification of eligibility. For example, Vermont has implemented a streamlining effort through WIC, and Los Angeles County has implemented a similar initiative through the food stamp program (see Box 2).

Beyond these two primary forms of ELE, the strategy that has the greatest potential benefit for children is automatic enrollment, which uses a child's enrollment in an income-comparable public program as a basis for qualifying that child as income-eligible for Medicaid or SCHIP. In California, for example, a new law will enable schools to use information from school lunch program applications to enroll children in the state's Medicaid program, a process that combines express lane and presumptive eligibility.[6] (See Box 3.) Also called adjunctive eligibility, automatic enrollment is already in place in other programs. For instance, since 1989, WIC agencies have been able to accept an applicant's documented participation in Medicaid, food stamps, or Temporary Assistance for Needy Families (TANF) as evidence of income eligibility for WIC.[7] Automatic enrollment has not been widely used in Medicaid and SCHIP, largely because it involves reconciling eligibility criteria for different programs and is therefore difficult to implement.[8] Thus, while valuable progress has been made in streamlining enrollment processes, many challenges remain.

Challenges to Implementing ELE Strategies

Although ELE offers the potential to find children and enroll them in health insurance programs, inherent difficulties remain in coordinating enrollment across different programs. ELE will also vary from state to state, depending on the state's eligibility rules for health insurance, policies concerning immigrants, level of integration between Medicaid and SCHIP, technological capacity, and ability to coordinate programs across agencies. This section describes the barriers to creating a more unified system across public programs and suggests strategies for overcoming them.

Box 1

Targeted Outreach: Ohio's School Lunch Program

In 2001–2002, all Ohio public schools were required to include a one-page health insurance addendum along with the school lunch application sent to parents. The addendum asked families interested in obtaining free or low-cost health care to complete and return the form with the school lunch application. Schools then sent these forms to the state, which mailed interested families an application for Healthy Start, Healthy Families, the state's Medicaid and SCHIP program. In Cincinnati, the public schools went further, entering the information from the addendum into a database that was then transferred to an outreach contractor for follow-up and application assistance.

In the program's first year (2001–2002), 47% of families who requested applications received health insurance for their children. Among the rest, 32% were already covered by public health insurance, 11% were denied enrollment, and 7% did not complete the process.

Source: Ohio Department of Job and Family Services and Ohio Family and Children First. ODJFS and OFCF school based outreach. Internal report. 2002.

Box 2

Streamlined Application: Vermont's WIC Program and Los Angeles County's Food Stamp Program

Both the state of Vermont and Los Angeles County have sought to streamline enrollment into public health insurance by using information that families provide when they apply to other programs.

Vermont's WIC Program

Vermont has coordinated its Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and its health program application and enrollment systems. WIC's income-eligibility guidelines (up to 185% of the FPL) are far below those of Vermont's health programs (up to 300% of the FPL).

An applicant to WIC or Medicaid/Dr. Dynasaur (Vermont's Medicaid and SCHIP programs) completes a single application and submits it to either program agency. The agency determines eligibility for its program and forwards the application to the other agency for review. Medicaid/Dr. Dynasaur adopts WIC's income determination, although each case is reviewed to see if income needs to be redetermined for health coverage purposes because of slight differences in the way such incomes are calculated. The health programs must also explore any outstanding issues beyond income, such as citizenship, which the health insurance application addresses, but the WIC processing team does not check. As a result of this process, 97% of Vermont's children on WIC had health insurance at the time of their most recent WIC visit.

Los Angeles County's Food Stamp Program

In Los Angeles County, the Department of Public Social Services (DPSS) recognized that the food stamp program was perhaps the most straightforward way to get started with express lane eligibility. The program has an income threshold comparable to most states' Medicaid programs, imposes strict eligibility rules, maintains current data, and is usually administered by the same agency or the same eligibility workers. DPSS implemented a system to ensure that all children enrolled in the food stamp program were also enrolled in Medi-Cal (California's Medicaid program). Staff conducted a computer search to locate all families with children enrolled in food stamps but not Medi-Cal and sent them a notice of potential eligibility. The notice included a card that the family could sign and return, authorizing the county to access the family's food stamp case file. DPSS then used the information and documentation provided on the food stamp application, and through any periodic reporting, to determine the child's Medi-Cal eligibility. More than 1,000 children were enrolled in Medi-Cal in this manner.

Sources: Vermont Department of Health. Insurance status of WIC participants—all district offices. Internal report. March 2002; Los Angeles County Department of Public Social Services. Medi-Cal outreach to uninsured food stamp families. Internal report. May 9, 2000.

Eligibility Rules

Public benefit programs have different eligibility rules pursuant to federal and/or state law. Where eligibility rules differ across programs, states may have to develop a system for following up with families to obtain additional information or documentation needed for a Medicaid/SCHIP determination. Alternatively, states may amend Medicaid/SCHIP rules to make them expansive enough to accept another program's eligibility determination.

For instance, food stamp programs calculate income eligibility based on household income, while Medicaid and SCHIP base eligibility on family income, which potentially incorporates fewer people and/or fewer incomes. A state that wanted to use a food stamp application to make a Medicaid determination could follow up as needed with an applicant to determine which household members were part of the applicant's family. Taking compatibility one step further, states that impose an assets test for health coverage might consider eliminating it, thus making the WIC or school lunch income determinations more relevant to the health program determination (since those programs impose no assets test).

The Centers for Medicare and Medicaid Services allows state Medicaid agencies to accept other programs' determinations, provided that those programs have rules for determining eligibility (such as the income methodology used to assess income) that are equally or more restrictive than the rules in Medicaid.[9]

States' comfort with automatic eligibility would be greatly enhanced by federal legislation that specifically authorized states to accept an income determination made by other specified public program agencies, irrespective of differences in methodology (if doing so would not adversely impact the error rate). Without federal express lane legislation, automatic eligibility is possible through creative planning, but its design is likely to be more administratively complex and less cost effective.

Immigration Requirements

Differences in program eligibility rules also pose challenges when it comes to serving noncitizen families. Some public programs have less restrictive requirements regarding immigrant status than do Medicaid and

Box 3

Automatic Enrollment: California's School Lunch Program

In October 2001, California passed a law that combines automatic express lane eligibility with a presumptive eligibility process, allowing children to immediately receive Medi-Cal (California's Medicaid program) coverage, based on information from their school lunch applications.[a]

In California, Medi-Cal for children ages one to five extends up to 133% of the FPL, and for older children to 100%, while free school lunch eligibility extends up to 130% of the FPL. Approximately 69% of California's low-income, uninsured children are in families that participate in school lunch.[b]

To implement the new law, schools will modify school lunch applications, requesting parental consent to share the information on the application with Medi-Cal, and gathering some additional information, such as information on family relationships. Children under age six who are eligible for free meals will be considered "express eligible"—automatically determined to have met the income requirements for Medi-Cal. The school or other designated entity will review applications of children age six and above (who may have family incomes above Medi-Cal eligibility levels) to determine family income, based on Medi-Cal's household rules. The school lunch program counts income for all members in the household, while Medi-Cal's rules are more limiting, so almost all children age six and above will be easily certified as income-eligible for Medi-Cal (express eligible).[c]

The school will transfer all applications with parental consent to the county Medi-Cal office. The county will enroll express eligible children into Medi-Cal and send each family a benefits card that enables a child to access services while his or her application undergoes further review. As part of the review process, the county will have to follow up with most families to obtain additional information, particularly immigration status, unless the information is available through existing databases. Children who are not eligible for express enrollment will also be contacted for additional information for a Medi-Cal determination; however, they will not receive benefits while their applications are being reviewed.

A number of school districts were prepared to implement express enrollment in the summer of 2002, but budget shortfalls led the governor to delay implementation until July 2003. School districts and counties are currently planning to launch the program in the 2003 school year.[d]

[a] *An act to amend Sections 49075, 49557, and 49558 of, and to add Section 49557.2 to, the Education Code, and to add Sections 10618.5 and 14005.41 to the Welfare and Institutions Code, relating to human services.* California Statutes and Amendments to the Code, chapter 894. 2001.

[b] Urban Institute. Uninsured children and program participation, California and the U.S., 1997–1999. Unpublished tabulations from the 1997 and 1999 National Survey of America's Families. 2002. "Low-income" refers to those with family incomes at or below 200% of the FPL.

[c] California Health and Human Services Agency and Department of Health Services. Internal documents. 2002.

[d] Interviews with school district staff, including staff at the Los Angeles Unified School District, the San Diego Unified School District, and the Fresno Unified School District, February 2003. Information on the status of implementation can be found at http://www.expresslaneca.info.

SCHIP. For instance, federal law requires Medicaid and SCHIP to establish the citizenship and immigration status of applicants, but it does not require WIC and school lunch to do so.[10]

Working with immigrants regarding eligibility for public programs requires extra sensitivity to their concerns about being viewed as public charges. (See the article by Lessard and Ku in this journal issue.) Therefore, any administrative links between Medicaid/SCHIP and other programs would need to respect the trust established between families and other program agencies. Families would need to consent to share the information they provide to another public program and know that they may be asked for additional information, such as immigration documents, to determine eligibility for health insurance. Similarly, families would need reassurance that their eligibility for the other program would not be affected and that the information would be used only to make a Medicaid/SCHIP determination. States would also need to test forms and procedures with immigrants and monitor uptake of the public programs to ensure minimal falloff in enrollment as a result of ELE.

Integration between SCHIP and Medicaid

The compatibility between public health programs themselves is as important as the compatibility between public health and other public programs. States that opted for separate SCHIP rather than Medicaid expansions must address eligibility and administrative differences between the two health programs as they design an ELE system. Steps include: ensuring that information can easily be transmitted between programs; designing procedures that guarantee that Medicaid-eligible children are enrolled in Medicaid rather than SCHIP; and developing a system to ensure that the state receives enhanced federal matching rates, where appropriate. Because of differences between programs, careful planning and strategy development are key to any successful ELE project.

Technological Capacity

ELE can be most efficient across programs that have compatible computer systems, and data can be transferred between agencies. Computers can be used to add data to health care applications from other program applications, or to determine Medicaid/SCHIP eligibility using data from other program applications. Most states lack the technological infrastructure that allows

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information to be easily shared and enables automatic eligibility determinations between programs.[11]

Collaboration across Agencies and Programs

Express lane processes involve time and resource investment by non-Medicaid programs that are already operating at full capacity. To succeed, ELE requires that agencies collaborate and locate resources to support needed technological advances and personnel. Medicaid and SCHIP administrative funds can finance much of this work. But beyond funding, success hinges on non-Medicaid program staff understanding that this process is valuable, and on making the process as simple and rewarding as possible for all agencies involved.

For example, while families may know how to access school lunch, they may not have much experience with accessing and using health care systems, a problem that can be exacerbated by cultural differences with regard to health and health insurance. (See the article by Lessard and Ku.) When school lunch and Medicaid agencies work together, however, a family's ties to school lunch can smooth the way to enrolling children in public health coverage and an appropriate medical home.

Next Steps for States

In assessing their opportunities for implementing express lane eligibility, states should consider a number of factors. More effective and efficient public health insurance programs for children are likely if states do the following:

- Review other program guidelines to determine which are best aligned with the state's existing Medicaid and SCHIP guidelines.
- Choose programs operated by agencies that have a good working relationship with the health care

agency(ies) and preferably have or can develop the capacity to share information electronically.

- Determine which programs enroll the largest proportion of uninsured children, thus meriting the effort of ELE. If this information is not available, examine the rate of uninsurance among different age groups, and choose programs that serve the least insured age group (infants, preschoolers, or school-agers).
- Where the state operates SCHIP separately, avoid screening and enrollment problems by targeting ELE to Medicaid-eligible children, if possible.
- Assess whether it is most effective and feasible to implement the program at a county/local level or at a state level.
- Consider using presumptive eligibility when a child is referred to a public health insurance program by another program. This process would allow the child to be presumed eligible for health insurance and receive needed services while the state makes a final eligibility determination (see the article by Klein in this journal issue).

Conclusion

Although significant challenges remain to implementing an express lane strategy, successful ELE strategies offer the opportunity to enroll and retain millions of uninsured children in public health programs, improve administrative efficiencies, and simplify enrollment processes. Longer term, ELE offers a first step toward coordinating valuable public service programs that benefit low-income children, making it easier for children to access a range of services they need to improve their well-being and quality of life.

ENDNOTES

1. Dubay, L., Haley, J., and Kenney, G. *Children's eligibility for Medicaid and SCHIP: A view from 2000.* Washington, DC: Urban Institute, March 2002, series B, no. B-41, p. 3. "Low-income" refers to those with family incomes at or below 200% of the FPL.
2. Kenney, G., and Haley, J. Unpublished data compiled at the Urban Institute, May 2002; Uninsured children and program participation, the U.S., 1999. Unpublished tabulations from the National Survey of America's Families, 1999.
3. Currently, 40 states provide Medicaid or SCHIP to children with family incomes at or above 200% of the FPL. Mann, C. Address to the U.S. Senate Subcommittee on Public Health on "Issues Facing Medicaid and CHIP." Washington, DC, March 12, 2002. The food stamp program covers households with gross incomes up to 130% of the FPL, WIC covers families up to 185% of the FPL, and school lunch covers households with incomes up to 130% of the FPL for free meals and up to 185% of the FPL for reduced-price meals. Horner, D., Morrow, B., and Lazarus, W. *Putting express lane eligibility into practice.* Washington, DC: Children's Partnership and Kaiser Commission on Medicaid and the Uninsured, November 2000. Available online at http://www.expresslane.info.
4. See note 2, Kenney and Haley. These 3.7 million uninsured children represent 23% of the low-income children receiving school lunch, or 58% of low-income, uninsured children. Urban Institute tabulations also found that 1.3 million low-income, uninsured children participate in WIC (15% of WIC children, 21% of low-income, uninsured children), and 370,000 participate in food stamps (6% of food stamp children, 6% of low-income, uninsured children).
5. The term "express lane eligibility" was coined by The Children's Partnership. See note 3, Horner, et al.
6. For further information about presumptive eligibility, see the article by Klein in this journal issue.
7. *Omnibus Budget Reconciliation Act of 1989*, Public Law 101-147, 7 CFR § 246.7(d)(2)(vi). 101st Congress, November 10, 1989.
8. Pursuant to federal law, automatic eligibility for Medicaid without a separate Medicaid application exists for Social Security Income (SSI) recipients in some states. 42 CFR § 435.909. Prior to welfare reform, Aid to Families with Dependent Children (AFDC) enrollment also established automatic Medicaid eligibility. Schneider, A., Fennel, K., and Long, P. *Medicaid eligibility for families and children.* Washington, DC: Kaiser Commission on Medicaid and the Uninsured, September 1998, p. 7.
9. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. *Continuing the progress: Enrolling and retaining low-income families and children in health coverage.* Washington, DC: DHHS, CMMS, August 2001, p. 11.
10. Health Care Financing Administration. Letter to state health and welfare officials. September 21, 2000.
11. For example, see Cohen Ross, D. *Enrolling children in health coverage: It can start with school lunch.* Washington, DC: Center on Budget and Policy Priorities, January 2001.

Presumptive Eligibility

Rachel Klein

When Congress established the State Children's Health Insurance Program (SCHIP) in 1997, it also enacted presumptive eligibility, a new state option for expediting children's enrollment in Medicaid.[1] Presumptive eligibility helps states cover children more quickly by allowing them to provide immediate, but temporary, enrollment in Medicaid or SCHIP to children who appear to meet program eligibility standards. During a period of presumptive eligibility, children have access to the full range of Medicaid- or SCHIP-covered services (for whichever program they are presumed to be eligible), allowing them to receive needed health care immediately rather than waiting for completion of a full eligibility determination. This approach facilitates access to care for uninsured children and contributes to state efforts to increase participation in Medicaid and SCHIP.

This article provides an overview of presumptive eligibility as a strategy for increasing participation in Medicaid and SCHIP. In addition to describing the process of determining presumptive eligibility and its benefits for children, the article also examines some concerns that have slowed the widespread adoption of presumptive eligibility to date. Finally, the article discusses possible solutions that will enable presumptive eligibility to meet its potential to quickly cover eligible children and increase the continuity of their care.

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How Presumptive Eligibility Works

To expedite the process of enrolling eligible children in public health programs, presumptive eligibility uses two strategies: an expedited application process, and community-based outreach and enrollment.

With presumptive eligibility, states can provide immediate coverage to children in families with gross incomes below Medicaid or SCHIP eligibility levels, instead of waiting for a full determination of eligibility. To keep coverage, families must be found eligible through the regular application process by the end of the month following the initial application, or the temporary coverage will expire.[2] States receive federal matching funds for the costs of covering children who are presumed eligible: If the child is presumed eligible for Medicaid, the state receives its regular federal match; if the child is presumed eligible for SCHIP, the state receives the higher SCHIP federal match.[3] States receive the federal match even if the child is later found to be ineligible.[4] In December 2000, Congress enacted legislation that changed these rules somewhat, giving states more incentive to adopt presumptive eligibility in separate SCHIP programs and making it easier for states to coordinate Medicaid and SCHIP presumptive eligibility.[5] (See Box 1.)

Presumptive eligibility helps states move the enrollment process into the community in a way that Medicaid rules would not otherwise permit. By allowing states to empower health care providers, certain community-based organizations that serve low-income

Box 1

Increased Incentives for Financing Presumptive Eligibility

The financing of presumptive eligibility for children depends on how states choose to implement the program: States can choose to operate presumptive eligibility in Medicaid, SCHIP, or in both programs. Prior to the passage of the Benefits Improvement and Protection Act of 2000 (BIPA) in December 2000, states had more incentive to adopt presumptive eligibility in Medicaid than in SCHIP. Now, however, that incentive may have shifted because the funding mechanisms for presumptive eligibility were revised under the Act.

Prior to passage of BIPA, states assumed somewhat more risk in adopting presumptive eligibility in SCHIP than in Medicaid. In Medicaid, federal financial participation at the regular Medicaid matching rate is guaranteed for children presumed eligible, even if they are ultimately determined ineligible for Medicaid. In addition, Medicaid eligibility can begin as many as three months prior to the date of an application for Medicaid if the child would have been eligible during that time and had incurred medical bills, so presumptive eligibility may not add to the cost of delivering care to children who are sick or have a chronic condition. In SCHIP, the federal government would pay the enhanced SCHIP matching rate if the child was ultimately determined eligible for SCHIP. However, if a child was presumed eligible for SCHIP but determined eligible for Medicaid, the state would receive only the regular Medicaid match rate for services delivered to that child. Moreover, if a child presumed eligible for SCHIP was ultimately determined ineligible for either Medicaid or SCHIP, expenses were considered "direct health services" and charged to states' limited administrative and outreach funds.[a] Thus, with SCHIP presumptive eligibility, states could not know how much to expect from the federal government until each eligibility determination was complete, and they were unable to judge what expenses were likely to be charged as a "direct service" under SCHIP, leaving fewer administrative and outreach funds than they had planned.

With the passage of BIPA, the financing issues that dissuaded states from adopting presumptive eligibility in SCHIP have been addressed. States may now have more incentive to implement presumptive eligibility in SCHIP than in Medicaid: Provisions adopted in BIPA clarified that services delivered during a presumptive eligibility period will be charged to the states' regular SCHIP funds and not the restricted administration and outreach portion of the block grant. Further, federal regulations clarify that states will be reimbursed at the enhanced SCHIP match rate for services delivered to children who are presumed eligible for SCHIP, regardless of the outcome of the full eligibility determination. Likewise, states will receive the regular Medicaid match for children presumed eligible for Medicaid regardless of the outcome of the full eligibility determination.[b] Presumptive eligibility now can save the states money by increasing the federal government's contribution toward its cost: The government will reimburse states at the higher SCHIP rate for children who are initially presumed eligible for SCHIP but later found eligible for Medicaid.[c]

Source: Benefits Improvement and Protection Act of 2000 (PL 106-554).

[a]States may spend up to 10% of their total annual SCHIP expenditures on administration, outreach, and "direct services" to children.
[b]States that expanded Medicaid instead of establishing a separate SCHIP program will receive the enhanced match for children determined eligible as part of the expansion group and not "regular" Medicaid.
[c]The "enhanced match" for SCHIP is the lower of 70% of the regular Medicaid match rate plus 30 percentage points or 85%. The federal government pays from 65% to 83% of the cost of providing coverage to children in FY 2002, while the Medicaid match rate is 50% to 75%.

children, schools, and certain government agencies to make presumptive eligibility determinations, presumptive eligibility helps connect outreach to enrollment. Box 2 provides an overview of entities that states can authorize to determine presumptive eligibility. Many of these entities are already engaged in efforts to find and help eligible children enroll in Medicaid and SCHIP. Presumptive eligibility allows them to take the next step of actually enrolling children on an immediate but temporary basis.

States have discretion to decide which of the approved entities they will authorize to make presumptive eligibility determinations and how many individual qualified entities will be certified. New Mexico, for example, has trained and certified more than 1,100 individuals in local health departments, the Indian Health Service, Head Start programs, several school systems, and the Division of Children and Families (which approves child care subsidy applications).[6] New Jersey, by contrast, limits the definition of qualified entities to hospital-based clinics, federally qualified health centers, and local health departments delivering primary health care services.

In order for presumptive eligibility to work efficiently, the state should ensure that qualified entities have the capacity to handle presumptive eligibility determinations and that the individuals making presumptive eligibility decisions are knowledgeable about Medicaid and SCHIP eligibility rules and the application process. In addition to training, ongoing coordination between the state Medicaid/SCHIP agency and qualified entities is key to ensuring that staff at qualified entity organizations are kept abreast of eligibility policy changes and that new staff joining a qualified entity undergo training. The capacity of a qualified entity to conduct presumptive eligibility determinations is important because the most successful presumptive eligibility programs are those that conduct intensive follow-up with families to gather the documentation that the Medicaid or SCHIP agency requires to complete the application process. If a state has streamlined the application process by eliminating documentation requirements, however, it may not need to conduct as much follow-up with families. For a description of the process for presumptively enrolling children in Medicaid and SCHIP, see Figure 1.

Box 2

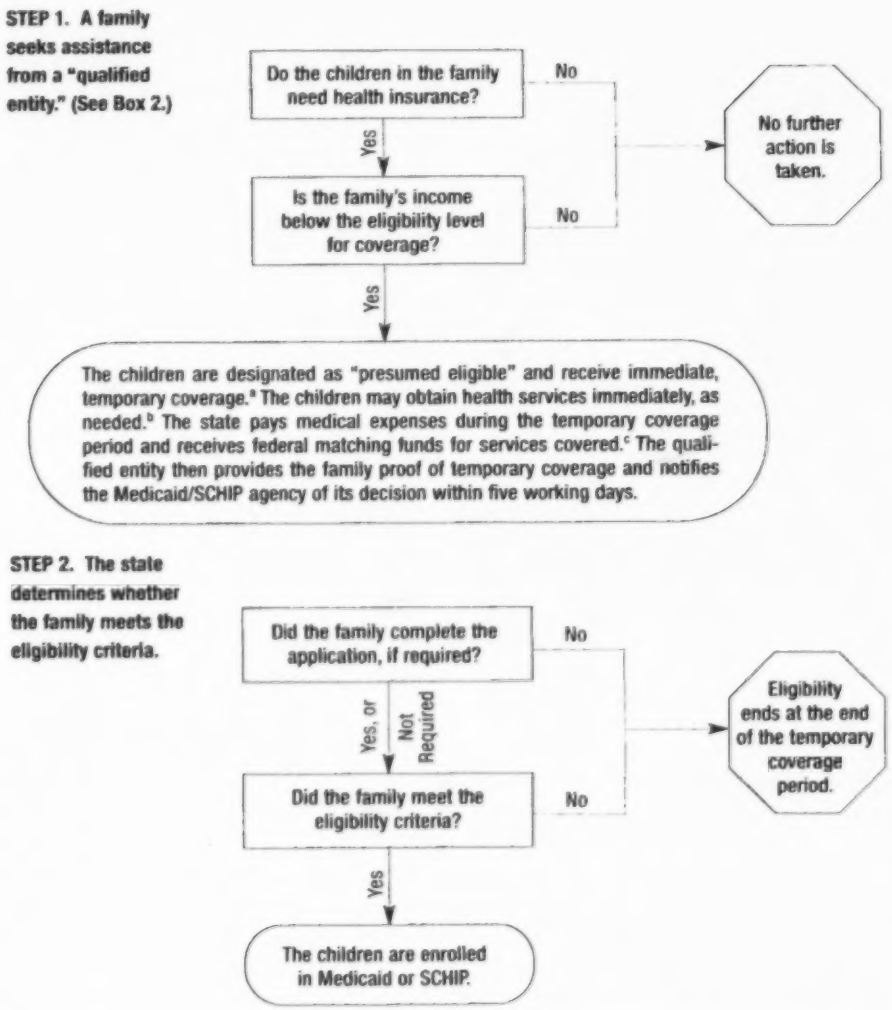
Entities Qualified to Determine Presumptive Eligibility

- Medicaid providers
- Primary or secondary schools
- Agencies administering Medicaid, SCHIP, or Temporary Assistance for Needy Families (TANF)
- Agencies that determine eligibility for Head Start
- Agencies that determine eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Agencies that determine eligibility for the Child Care and Development Fund
- Child support enforcement agencies
- Agencies that determine eligibility for federal housing assistance programs
- Organizations that provide emergency food and shelter under a grant from the Stewart B. McKinney Homeless Assistance Act
- Any other entity a state chooses, if approved by the Secretary of Health and Human Services

Source: Section 1920A of the Social Security Act, 42 U.S.C. 1396r-1a.

Figure 1

Presumptive Eligibility Enrollment Process


STEP 1. A family seeks assistance from a "qualified entity." (See Box 2.)
Do the children in the family need health insurance?
No
Yes
No further action is taken.
Is the family's income below the eligibility level for coverage?
No
Yes
The children are designated as "presumed eligible" and receive immediate, temporary coverage.[a] The children may obtain health services immediately, as needed.[b] The state pays medical expenses during the temporary coverage period and receives federal matching funds for services covered.[c] The qualified entity then provides the family proof of temporary coverage and notifies the Medicaid/SCHIP agency of its decision within five working days.
STEP 2. The state determines whether the family meets the eligibility criteria.
Did the family complete the application, if required?
No
Yes, or
Not Required
Eligibility ends at the end of the temporary coverage period.
Did the family meet the eligibility criteria?
No
Yes
The children are enrolled in Medicaid or SCHIP.

[a]Children may be presumed eligible for a period of up to 60 days or until a "regular" eligibility determination is made by the state.

[b]When children who are presumed eligible have an immediate health need, workers can help their families schedule an appointment with any Medicaid/SCHIP health care provider. If the entity making the presumptive eligibility determination is a health care provider, that provider can immediately deliver care and the state will reimburse for the services provided.

[c]Even if the child is ultimately found ineligible, medical expenses incurred during the presumptive eligibility period will be covered, and the state will receive its federal matching funds for those expenses.

Source: Adapted from federal law and regulations (Section 1920A of the Social Security Act).

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Benefits of Presumptive Eligibility for Children

Presumptive eligibility offers several benefits for children and for states administering the program. It can be an effective way to improve outreach, access to care, and enrollment in children's health coverage programs, whether through Medicaid or SCHIP.

Outreach

Presumptive eligibility bridges the gap between outreach and enrollment. It allows states to bring the enrollment process into the community, where qualified entities can engage in outreach, and families can both learn about children's health insurance and receive coverage from a known and accessible source.

Community settings may provide convenient and familiar sites for families to learn about health coverage options for their children. In a 1999 national survey, more than one-half of low-income families of uninsured children reported that the ability to enroll immediately and provide forms later, combined with the opportunity to enroll at a doctor's office or clinic, would make them "much more likely" to enroll their children in Medicaid.[7] Besides being convenient to families, presumptive eligibility offers qualified entities an added incentive to engage in outreach to their patients and clients, many of whom are likely to be eligible for children's health coverage. Entities that are providers know they will be paid for their services and have the opportunity to provide follow-up care to children who need it. Other entities, such as schools, Head Start agencies, and Child Care and Development Funds can use the presumptive eligibility process to help children receive immunizations, eyeglasses, dental care, or physicals, improving the health of the children they already serve.

Access to Care

Presumptive eligibility can make health care services available much more quickly than is possible under the regular eligibility determination process. For example, qualified entities can make presumptive eligibility determinations on the same day a family applies. If entities are medical providers, they can provide care immediately. Other entities can help families get appointments with providers. In contrast, Medicaid and SCHIP rules allow states to take up to 45 days from the date of application to determine eligibility.[8] Some states have successfully expedited their application-processing times by simplifying applications and reducing documentation requirements,[9] but children may still face long application periods when agencies receive a high volume of applications. Additionally, while Medicaid coverage begins as

Ensuring quick access to services prevents health problems from worsening and enhances continuity and coordination of care.

soon as the determination is made, in separate children's health plans, coverage typically does not begin until the first of the following month.[10] Therefore, a child found eligible on March 10, for example, will likely have to wait until April 1 for coverage to begin. A 2000 survey of families with children newly enrolled in the Florida KidCare program found that 3 out of 10 families faced application-processing times of more than two months.[11] One-fifth of the families reported a delay in seeking medical care for financial reasons while awaiting coverage. Almost one-half of the families who did get medical care for their children while awaiting coverage paid more than $50.

Ensuring quick access to services prevents health problems from worsening and enhances continuity and coordination of care. For instance, families may be reluctant to seek care without knowing that a pending application will eventually be approved to cover the bill, even though delayed care can sometimes mean more serious and expensive intervention later.[12] If a family does seek care, a child with a pending Medicaid/SCHIP application may be unable to find a provider who will deliver care, except in an emergency. Finally, immediate access can enhance coordination of care. For example, a health clinic can schedule follow-up care, a Head Start program or school can arrange for immunizations, a nutrition program can arrange treatment for an infant with baby-bottle tooth decay, and a child care eligibility site can offer benefits to families on its waiting list.[13]

Enrollment

Presumptive eligibility incorporates lessons learned from other efforts to increase children's enrollment in Medicaid and SCHIP. One lesson is that families are more likely to enroll if the process is simple and easy.[14] Another is that families are more likely to complete the enrollment process if they receive assurance that they are eligible and help in understanding the benefits of health coverage.[15] In addition, more families enroll when they can do so at a convenient location.[16] Presumptive eligibility can take advantage of these lessons by adding entry points and streamlining the process of applying for health coverage by piggybacking Medicaid or SCHIP applications with assistance from other social service programs. For instance, presumptive eligibility could be used in conjunction with express lane eligibility (ELE), allowing a determination to be based on information provided on an application for another assistance program, such as the National School Lunch Program. (See the article by Horner, Lazarus, and Morrow on ELE in this journal issue.)

Presumptive eligibility can also help streamline the enrollment process in states that have separate eligibility determinations for Medicaid and SCHIP. If a child applies for SCHIP but is found during the "screen and enroll" process to be eligible for Medicaid, the state agency could presume the child eligible for Medicaid while the application is reviewed. Likewise, a family that applies for Medicaid but is found to have too much income could be presumed eligible for SCHIP while the application is pending. A state could also use this mechanism at renewal to help children maintain coverage through changes in circumstances that shift their eligibility from SCHIP to Medicaid or vice versa. (See the article by Cohen Ross and Hill in this journal issue for a more complete discussion of outreach and enrollment.)

Concerns Regarding Presumptive Eligibility

Despite its benefits, presumptive eligibility has not been widely adopted. Table 1 shows that, as of May 2002, only nine states have authorized presumptive eligibility for children in their Medicaid programs, and only five states have authorized it in their SCHIP programs. Reasons for states' reluctance to adopt presumptive eligibility include concerns about cost implications and questions about whether presumptive eligibility is necessary when states have simplified the application and enrollment process.

Cost Implications

In this era of budget shortfalls, states may be wary of proposals that carry new cost implications. Presumptive eligibility, like any outreach and enrollment innovation, carries both administrative costs (for example, training qualified entities and processing applications) and programmatic costs (such as delivering health services during a presumptive eligibility period). In addition, some state officials have expressed concern that presumptive eligibility would put states at risk of providing expensive health

Table 1

States That Have Adopted Presumptive Eligibility for Children as of August 2002

Presumptive Eligibility in Medicaid	Presumptive Eligibility in SCHIP
Connecticut	Massachusetts
Florida[a]	Michigan[a]
Massachusetts	Mississippi[a]
Mississippi[a]	New Jersey
Missouri[a]	New York
Nebraska	
New Hampshire	
New Jersey	
New Mexico	
New York[a]	

[a]These states have adopted but not implemented presumptive eligibility as of August 2002.

Source: Information collected by Families USA based on SCHIP plans submitted to the U.S. Department of Health and Human Services, and conversations with state Medicaid and SCHIP officials, 2000–2002.

care services to children who are not actually eligible for—or do not enroll in—health coverage.

Anecdotal evidence suggests that states that have implemented presumptive eligibility have found that, with proper follow-up on the part of qualified entities, most families are successfully enrolled in Medicaid or SCHIP following a presumptive eligibility determination.[17] For example, in Fiscal Year 2001, Nebraska had a 76% approval rate for ongoing coverage of children presumed eligible for Kids Connection, the state's Medicaid expansion program for children.[18] One of the largest qualified entities in the state reported an approval rate of 86%.[19] To encourage families to follow through with the enrollment process, states have generally limited the number of times a child can be presumed eligible to once every 12 months. A high approval and enrollment rate for presumptive eligibility applications indicates that states are generally providing care only to children who are, in fact, eligible for Medicaid or SCHIP.

In addition, available evidence appears to indicate that children who are presumptively enrolled do not have significantly more expensive health care needs than children who are enrolled through the regular application process. For example, in an average month in Fiscal Year 2001, Nebraska served 315 children through presumptive eligibility at a cost of $172.23 each, which was nearly identical to the cost of coverage for a child enrolled regularly in Kids Connection.[20] Furthermore, preventive care or treatment provided to a child during the presumptive eligibility period may save a state the cost of more expensive treatment later on, for a condition left untreated during the wait for enrollment in ongoing coverage. States that have adopted presumptive eligibility tend to agree that the benefits and cost savings achieved through addressing health care needs up front have outweighed the administrative burden of establishing a presumptive eligibility program.[21]

The Need for Presumptive Eligibility

Another concern is that simplified application processes and retroactive Medicaid coverage for children make presumptive eligibility unnecessary.[22] In fact, states have made it significantly easier to apply for children's coverage under Medicaid and SCHIP.[23] But presumptive eligibility is still useful for increasing access to coverage. Despite simplified applications, application-processing times may vary considerably, between Medicaid and SCHIP programs across counties, or at times when demand increases, such as when children go back to school in the fall.[24] Presumptive eligibility could help ease those disparities. Moreover, although Medicaid has retroactive coverage, states generally have no comparable provision for retroactive SCHIP coverage,[25] and families may have difficulty getting health care services without proof of insurance. Even if an application is processed very quickly, there may still be a lag time before a child is covered and able to receive services.

Conclusion

Presumptive eligibility for children has the potential to offer affordable health care to more children and to increase continuity of care and follow-up services. Enabling health care providers and certain community-based organizations to enroll children immediately, while a regular application is pending, holds promise as a strategy for improved outreach, access to care, and enrollment.

ENDNOTES

1. *Social Security Act*, 42 U.S.C. 1396r-1a § 1920A (1997).
2. See note 1, *Social Security Act*. A period of presumptive eligibility lasts from the date the child is presumed eligible to the end of the following month (thus, up to 60 days). However, if the family submits an application for ongoing Medicaid or SCHIP coverage, or if the presumptive eligibility application is the same as the regular Medicaid or SCHIP application, the temporary coverage continues until a full eligibility determination is made.
3. The federal government shares the cost of Medicaid and SCHIP with the states. The federal government pays 50% to 75% of Medicaid costs. To give states incentive to expand coverage to children under SCHIP, the SCHIP statute authorizes the federal government to pay a higher percentage of SCHIP costs. In Fiscal Year 2002, the federal government paid 65% to 83% of SCHIP costs. *Social Security Act*, 42 USC § 1397ee (1997).
4. States that adopt presumptive eligibility in a Medicaid expansion will receive the regular federal match for children determined to be eligible for regular Medicaid and the enhanced SCHIP match for children made eligible through the expansion.
5. *Benefits Improvement and Protection Act of 2000*, Public Law 106-554. 2nd session, December 15, 2000.
6. Families USA. *Promising ideas in children's health insurance: Presumptive eligibility*. Washington, DC: Families USA, April 2000.
7. Lake, Snell, Perry, and Associates. *Medicaid and children: Overcoming barriers to enrollment: Findings from a national survey*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2000.
8. Once Medicaid eligibility is determined, eligibility begins on the date of application. Medicaid rules allow families to receive coverage for up to three months prior to the date of application if they were eligible during that time and incurred medical expenses for qualifying services. This rule enables providers who have delivered services but not been paid to bill Medicaid, and it enables families to be reimbursed (at the Medicaid rate) for out-of-pocket payment for covered services.
9. Cohen Ross, D., and Cox, L. *Making it simple: Medicaid for children and CHIP income eligibility guidelines and enrollment procedures*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2000.
10. Telephone survey of state SCHIP administrators, conducted by Families USA staff, June–August, 2000.
11. Institute for Child Health Policy. *Florida KidCare evaluation, year 2, Fiscal Year 2000: vol. 1: Narrative*. 2001. Available online at http://www.ichp.edu/FloridaKidCare/2000Reports/FlaKCEvalv1_FY2000.pdf.
12. Edmunds, M., and Coye, M.J., eds. *America's children. Health insurance and access to care*. Washington, DC: National Academy Press, 1998.
13. See note 6, Families USA.
14. See note 7, Lake, Snell, Perry, and Associates.
15. Kenney, G., and Haley, J. *Why aren't more uninsured children enrolled in Medicaid or SCHIP?* Washington, DC: Urban Institute, May 2001. Pernice, C., Riley, T., Perry, M., and Kannel, S. *Why eligible children lose or leave SCHIP: Findings from a comprehensive study of retention and disenrollment*. Portland, ME: National Academy of State Health Policy, February 2002.
16. See note 7, Lake, Snell, Perry, and Associates.
17. Personal communications with state presumptive eligibility staff: Sue Fiero, Medicaid program specialist, Nebraska Department of Health and Human Services, May 2002; Kate Frye, Policy and Program Planning, New Hampshire Health Care Services Division, Department of Health and Human Services, May 2002; Fran Smith, director of Medicaid in the Schools, School Health Unit, New Mexico Department of Education, December 2000.
18. See note 17, Personal communications with state presumptive eligibility staff.
19. Personal communication with Pat Lopez, Lancaster County Kids Connection, May 2002.
20. The average cost per child per month for children enrolled in Kids Connection is $172.31. Personal communication with Rob Stevenson, program analyst, Nebraska Department of Health and Human Services Office of Finance and Support, June 5, 2002.
21. See note 17, Personal communications with state presumptive eligibility staff.
22. Retroactive eligibility allows individuals to receive coverage for services they received prior to enrollment in Medicaid, and it allows providers to be paid for those services, but only if the individual is determined to have been eligible during that time. In contrast, presumptive eligibility allows a child to receive services, and the provider to be paid for those services, even if the child is ultimately found ineligible for Medicaid or SCHIP.
23. Cohen Ross, D., and Cox, L. *Enrolling children and families in health coverage: The promise of doing more*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, June 2002.
24. See note 17, Personal communications with state presumptive eligibility staff.
25. See note 10, Telephone survey of state SCHIP administrators.

Universal Health Care for Children: Two Local Initiatives

Liane A. Wong

Over the past decade, expansions under Medicaid and the State Children's Health Insurance Program (SCHIP) have brought a significant infusion of federal dollars into state and county health systems and have produced a variety of state-level programs. Yet, the expansion of public health insurance programs at the state level has had mixed success in providing coverage and improving access to care for children.[1] In some cases, states have fallen short of their enrollment projections because of barriers such as some children remaining ineligible for coverage[2] or families finding programs difficult to access.

In response to these barriers, counties and local communities have increasingly emerged as "hubs of innovation" by using creative strategies to make insurance coverage and access to care available to children who do not meet the state eligibility criteria. This article describes the programs of two counties that have attempted to expand access to care for children: the Children's Health Initiative in Santa Clara County, California; and the Kids Get Care program in King County, Washington. The Santa Clara County Children's Health Initiative (CHI) adopted an insurance expansion model through its local initiative health plan, while the King County Kids Get Care (KGC) program is a service coordination model that directly links families to community-based "medical homes."[3] The article begins by describing these two county-level programs and comparing the approach each has taken, then draws on these experiences to outline important elements for counties that want to create universal health care for children and families: committed leadership, health systems infrastructure, multiple financing sources, and community support.

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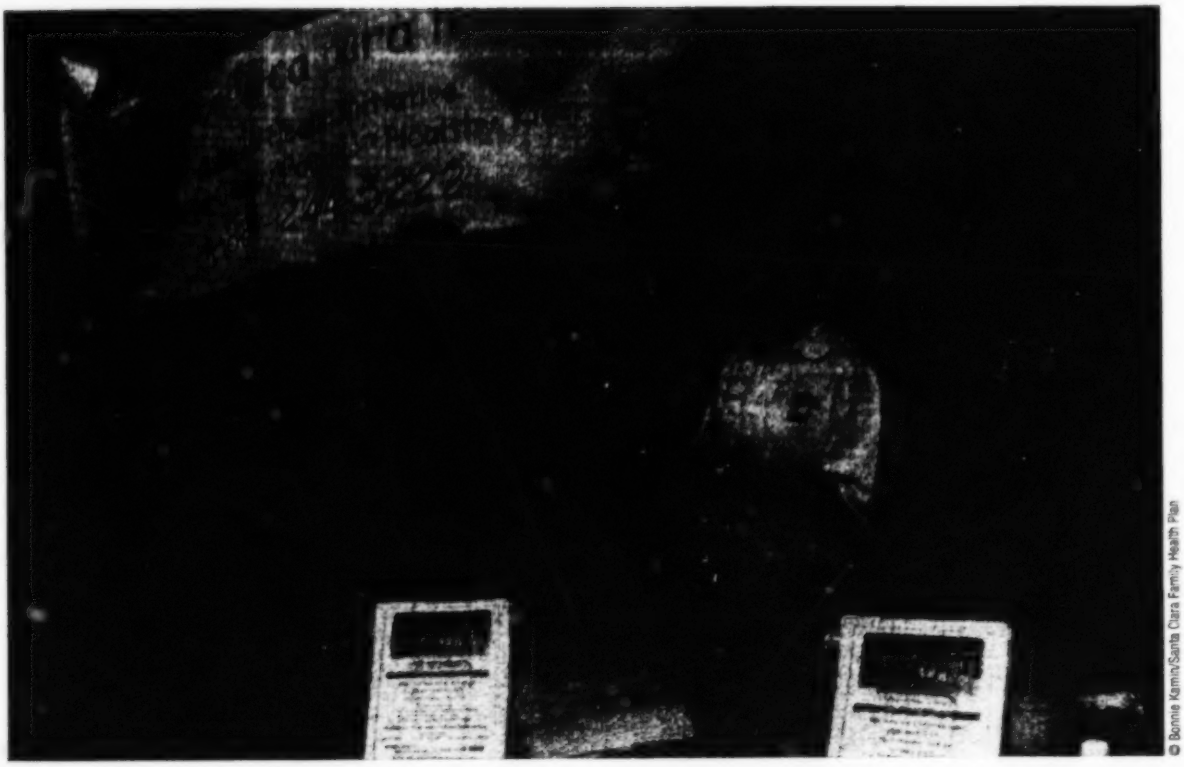
Two Models for Improving Children's Health Care Access in a Patchwork System

The Santa Clara County and King County initiatives were selected for study in this article for a variety of reasons. First and foremost, they took differing approaches to improving children's access to care, and the programs are at least 12 months into their implementation. In addition, both counties are home to highly diverse populations and have publicly financed delivery systems with the capacity to support activities proposed under each initiative. Finally, each county also has a major city with a moderate to high concentration of uninsured children—the city of San Jose in Santa Clara County and the city of Seattle in King County.

The counties are using two different approaches to move toward universal health care for children in otherwise patchwork health systems. The Santa Clara County CHI is a health insurance expansion with a focus on integrating funding and service delivery, while the King County KGC program is a services-based initiative that directly links the child to a community-



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based, integrated continuum of care. This section provides a more detailed description of the two counties and their children's health initiatives.

The Santa Clara County Children's Health Initiative

Located at the southern end of the San Francisco Bay Area, Santa Clara County is home to 1,736,722 residents; about 462,000 of them are under age 18.[4] Approximately 925,000 of the county's residents live in San Jose, the biggest and most populous city in the county.[5] The county has also witnessed tremendous growth in its racial and ethnic populations. Latinos currently comprise about 25% of the county's population, Asians and Pacific Islanders 20%, and African Americans about 4%. Santa Clara County, home to the original Silicon Valley and the high-tech industry, has been described as having an hourglass-shaped economy. While Santa Clara is a relatively affluent county with a large number of families earning above the national median household income,[6] many low- and moderate-income families struggle with escalating housing costs and the basic costs of living, including the cost of health insurance. In 2001, about 147,000 residents, or about 10% of the county's non-elderly population, were uninsured.[7] The most widely cited estimates indicate that 15% of the county's children (approximately 71,000) lack health insurance coverage.[8] Approximately 20% of the county's children are in families with incomes up to 300% of the federal poverty level (FPL).[9]

The Santa Clara County CHI is an insurance coverage expansion created through a unique public-private partnership involving county and city governing bodies, the local health and hospital system and social services agency, labor-affiliated and faith-based organizations, and private foundations. It seeks to provide health insurance coverage to all children in the county with family incomes up to 300% of the FPL.

The community advocacy groups (Working Partnerships USA, a labor-affiliated organization, and the faith-based People Acting in Community Together) mobilized their constituents and placed the issue of uni-

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Counties and local communities...[are]...using creative strategies to make insurance coverage and access to care available to children who do not meet the state eligibility criteria.

versal coverage for children on the local policy agenda. In 2000, health system leaders and community activists convened to initiate discussions on the need for broad-scale change to address the county's growing uninsured population. These meetings led to a series of hearings with county and city governing bodies, culminating in the allocation of several million dollars annually from public and private funding sources to the CHI.

Launched in January 2001, the CHI aims to provide comprehensive health, dental, and vision coverage to all children in the county under age 18 whose family incomes are at or below 300% of the FPL, or $52,950 a year for a family of four in 2002. (See Table 1.) To accomplish this goal, the initiative created a subsidized, private insurance program called Healthy Kids for low-income, uninsured children who do not qualify for Medicaid or SCHIP. The program also created a "single point of entry" model for enrolling children, whereby an entire family can enroll in health coverage through the CHI. The Healthy Kids program offers comprehensive health, dental, and vision benefits that are managed through the county's local Medicaid managed care plan, the Santa Clara Family Health Plan. In turn, the plan coordinates with the county's ambulatory facilities and affiliated community health centers to provide preventive and primary care services. Enrollees requiring specialty care or hospitalization are referred to one of seven local hospitals. The plan also contracts with private physicians throughout the county for primary and preventive services. By using coordinated outreach and enrollment through county district offices, health centers, and community-based organizations, the CHI enrolled more than 10,900 children in Healthy Kids by August 2002.[10]

The King County Kids Get Care Program

King County is the largest county in the state of Washington, with a total population of 1,737,034, of which nearly 400,000 are children (ages 0 to 17).[11] In 2000, about 9% of these children, or about 35,000, were uninsured, and more than 100,000 were estimated as underinsured.[12] The city of Seattle is a major metropolitan area and is home to more than 560,000 of the county's residents.[13] In recent years, King County has experienced a 13% increase in its total population and a 15% increase in ethnic minority residents. Census 2000 data indicate that approximately 27% of the county's children belong to an ethnic minority group, and 21% are in families with incomes below 250% of the FPL.[14] The KGC program targets its activities in the three geographic areas with the highest number of children in this income category: Seattle's Central Area, East King County, and South King County.

The KGC program emerged in the wake of the state's failed attempt at health care reform, coupled with rising concerns about families' confusion in navigating among several public programs, including the state's Basic Health Plan.[15] The KGC program focused on strategies to connect the county's children to medical homes, in response to the fact that many were not accessing services, although a relatively high percentage of them had health insurance coverage.[16] The benefits of a medical home, which can be a physician's office, hospital outpatient clinic, community health clinic, or school-based clinic, are improved health outcomes through continuity of care with a known and trusted provider.[17] Nonetheless, program sponsors estimate that nearly 70,000 children in the three geographic regions lack a medical home.

In 2001, the program was developed by a coalition of 30 organizations called the King County Health Action Plan. (See Table 1.) The program was conceptualized in two phases. In the initial phase of the program, networks were created to directly link child care providers and children's programs to community-based health centers in South, Central, and East King County.[18] Providers were trained through the KGC program to screen children for developmental, oral, and behavioral health conditions. Children and families then are connected to the nearest participating safety net clinic ("hub site") for appropriate services and assistance with enrollment in public programs. Children with special health needs received referrals to specialty care.

Table 1

Key Features of Two County Initiatives to Reach Uninsured Children

	Santa Clara Children's Health Initiative, Santa Clara County, California	Kids Get Care Program, King County, Washington
Implementation Launched	January 2001	September 2001
Services	Outpatient primary and specialty care; inpatient care; emergency, dental, pharmacy, vision, mental health, and preventive care services	Comprehensive primary care and referral to specialty care, with an emphasis on integrated, preventive oral, physical, and developmental services. Community-based risk assessment, screening, linkages, and provider training
Cost Sharing	Monthly premiums are set between four dollars to six dollars per child, depending on family income, with five dollars co-payments for office visits, prescription drugs, outpatient mental health visits, and physical therapy	Cost sharing varies depending on the program and the clinic. There is no cost sharing for Medicaid, and the Basic Health Plan's monthly premium varies. Each hub site has a sliding fee scale for children who are ineligible for public programs
Eligibility	Children ages 0 through 18 with family incomes less than 300% of the FPL, regardless of immigration status	Children ages 0 through 18, regardless of insurance and immigration status; first-year emphasis on birth through age 5
Financing	$11 million to $12 million annually: $3 million from the county's share of the National Tobacco Settlement, $2 million from the Children and Families First Commission, $1.2 million from the city of San Jose, $1 million from the Santa Clara Family Health Plan, and $4 million from private foundations	$989,170 first-year funding from the HRSA Community Access Program, $240,000 from the city of Seattle, and $113,700 for the first of three possible years from the Washington Dental Service Foundation to expand its oral health component
Key Partners	Santa Clara Valley Health and Hospital System Santa Clara Social Services Agency Santa Clara Family Health Plan Working Partnerships USA People Acting in Community Together Santa Clara Board of Supervisors City of San Jose Community Health Partnership The Health Trust The David and Lucile Packard Foundation	King County Health Action Plan Public Health–Seattle and King County Washington Health Foundation Washington Dental Service Foundation Community Health Centers of King County Central Area Health Care Center Children's Hospital and Regional Medical Center City of Seattle Harborview Medical Center
Number of Children Served	10,900 children enrolled	18,000 children screened and 3,000 children connected to a medical home

Through this process, parents were encouraged and assisted in establishing a health care home for their children, and the KGC program offered subsidized services for children who were ineligible for public coverage. The program sought to connect approximately 3,000 children to medical homes through the KGC pilot in the first year of the project, and an additional 4,000 in the second year.[19] By August 2002, the KGC program had screened 18,000 children and connected 3,000 to one of three designated safety net clinics.[20]

During the second phase of the program, which began in July 2002, the KGC program will enhance efforts for early detection of children's mental health needs and expand the oral health component to an additional 7 sites in King County, with the goal of offering the entire program at 10 safety net clinics by 2004.[21]

Program Similarities and Differences

The CHI and KGC programs share a number of features, such as a vision of expanding access to care for all children in their geographic areas, a reliance on existing safety net providers, and a foundation built from public-private collaboration. Both programs aim to provide health care access by expanding existing infrastructure, and each is connected to a public entity. Yet, differences between the programs emerge in their methods of financing, scope of services, and enrollment systems.

Financing and Costs

The two programs relied on different funding sources for their initiatives, which had implications for the time needed to implement the programs.

The Santa Clara initiative began when local constituencies mobilized to secure public funding for the cost of Healthy Kids premiums through the county of Santa Clara, the city of San Jose, and the county Children and Families First Commission, and then pursued private foundation and corporate funding.[22] Program developers continue to seek additional private funding through corporate employee match programs.[23]

Funding for the KGC program was launched primarily through a federal grant from the Health Resources and Services Administration (HRSA) and

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private foundation support. To date, most of the children receiving care through the KGC program are eligible for—or have insurance through—existing public programs but do not have a medical home.

The Santa Clara County CHI differed from the KGC program in its experience of building political momentum, developing its program structure, and expanding its core support with county and city tobacco settlement dollars. The convergence of these events led to a very short "ramp up" period—about 6 months—between the program's design and implementation phases. King County, however, was unable to pursue tobacco settlement dollars, as the state controls the allocation of these resources and had already earmarked these dollars for the Basic Health Plan. Instead, the architects of the program developed their program over a 12-month period with the assumption that it would need to be supported almost entirely through public and private funding sources.

Scope of Services

The scope of services offered by the CHI and the KGC programs varies significantly because of the different approach each took to expanding children's access to care. The KGC program follows an enhanced service-delivery model by providing comprehensive primary care and referrals to secondary and tertiary care through its safety-net-clinic hub sites. The program also emphasizes integrated preventive services, including oral and developmental health screenings for enrollees. The first year of HRSA funding was used to

establish the screening and referral networks, enhance case management, and subsidize comprehensive preventive services. The long-term goal for the program is to link all children in King County to a medical home.

In contrast, the CHI approach follows an insurance coverage model by providing and marketing to all children in lower-income families a comprehensive benefit package comparable to the SCHIP program. These services include outpatient primary and specialty care; inpatient care; and emergency, pharmacy, dental, vision, mental health, and preventive care services.

Enrollment Systems

In an effort to streamline enrollment processes, both programs are working to create paperless, computer- or Web-based enrollment systems. In addition, King County is taking the next step by trying to create a system that allows families to simultaneously apply for a number of public benefits for their children.

The KGC program used some of its first-year funds to link to a management information system that coordinates and enhances existing Web-based programs being piloted in Seattle and other parts of the state. The new system brings together Web-based eligibility-determination tools developed by the state Department of Social and Health Services. These technologies enable application workers to assess children's preliminary eligibility for a range of public benefits, including Medicaid, SCHIP, food stamps, housing assistance, child care, and the earned income tax credit. Although the system is still being refined, the average turnaround time for enrollment has been reduced from 28 to 14 days.[24] However, state and local deficits in 2002 and 2003 may jeopardize the continuity of this system.

In Santa Clara County, plans are also underway to use a Web-based application and eligibility-determination program called Health-e-App,[25] a paperless system that would allow for real-time eligibility determination. This technology also allows state-certified application workers to help families apply for public health insurance programs.

As in King County, plans are underway for a few counties to adapt the Health-e-App program to facilitate screening and eligibility determination for families in other public programs.

What Does It Take to Innovate?

Based on the experiences of these two programs, three elements seem crucial to moving toward a universal health care program for children—bringing together committed leadership and infrastructure, generating diverse community support, and leveraging public and private funding sources.

Bringing Together Committed Leadership and Infrastructure

Both counties have a safety net infrastructure with a public hospital, a network of community health clinics, and leadership that was actively involved in the planning, design, and early implementation phases of their respective programs. The executive director of the Santa Clara County health and hospital system was one of the driving forces behind the initiative and engaged the support of the county board of supervisors for children's access a year before the program was ultimately launched. In King County, a brainstorming session with key health leaders about why increased enrollment was not resulting in better access for children ultimately led to the creation of the KGC program.

Having a publicly financed delivery system probably also facilitated these conversations and action plans, but having the system alone would not have stimulated these initiatives. Counties with the administrative capacity, financial resources, and provider networks experienced in working with low-income communities are more likely to develop these types of innovative expansions. Health, government, and community leaders, working collaboratively and with a steadfast commitment to the larger goal of expanding health access to all children, were the "sparks" that made these programs a reality.

Generating Diverse Community Support

Community leaders and organizations played a catalytic role in developing and advocating for their respective programs. In Santa Clara County, two community groups, the labor-affiliated Working Partnerships USA and the faith-based People Acting in Community Together, championed the goal of 100% coverage for every child living in the county and exercised their political influence to promote this goal with county and city officials. They also mobilized hundreds of residents to testify at public hearings. With the initiative already 18 months underway,

both organizations continue to be actively engaged in the program's implementation and evaluation.

In King County, the active leadership of Health Action Plan partners such as the health department and the Washington Health Foundation continues to develop local support for future program expansion. While the role of local stakeholders will certainly differ in every county, capacity to generate the political will to launch a broad-based children's health initiative is crucial.

Leveraging Public and Private Funding Sources

Piecing together a viable funding strategy is another key component to these programs' inception and to their intermediate and long-term survival. Santa Clara and King Counties each managed to strategically access local revenue sources and leverage those dollars in an effective manner. Both programs have developed intermediate financing strategies that access foundation and corporate matching support, build from diverse public-private partnerships, and maximize available city and county revenues.[26] In addition, both programs have already begun to strategize about how best to leverage local public and private funding sources to secure sustainable state and federal funding for their children's access programs.

Sustaining the Momentum

In the face of severe budget shortfalls and new security and bioterrorism requirements following the terrorist attacks on September 11, 2001, local governments face greater constraints in shaping social programs. Yet, opportunities still exist for those concerned about guaranteeing children's access to appropriate and affordable health care. The Santa Clara County CHI and the King County KGC program are two models moving toward universal care that focus on integrating local health care delivery systems and aligning diverse resources to improve children's health.

The convergence of leadership and infrastructure, community catalysts, and funding was instrumental to the creation and sustenance of the CHI and the KGC programs. Each is a model in which local solutions were developed to address the problem of expanding access to care for low-income children. These local efforts, however, still face the ongoing challenge of securing long-term funding to sustain their activities. Financing options include efforts to access state or federal matching funds, organize the passage of a local tax initiative, and develop multiple strategies to attract private funding.

Because these programs are relatively new, data on their success in improving children's health outcomes or utilization of services are limited. Once evaluation data become available from the CHI and the KGC programs, each initiative's effectiveness in expanding children's access to care and improving their health outcomes will be better understood. Nonetheless, states and counties pursuing similar types of innovation can learn and benefit from the two different but successful approaches used by Santa Clara and King Counties to create universal health care for children. The strategies developed by these initiatives, and those that evolve from the programs that follow, will guide and inform the nation as policymakers and the public continue to grapple with the complex challenge of responding to the health care needs of uninsured children and families.

ENDNOTES

1. Lave, J.R., Keane, C.R., Lin, C.J., et al. The impact of the lack of health insurance on children. *Journal of Health and Social Policy* (1998) 10(2):57–73.
2. Due to state eligibility criteria, some children are not eligible for public programs because of their legal status or because their family income is too high.
3. The American Academy of Pediatrics defines a medical home as "medical care for infants, children and adolescents that is accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective. It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate all aspects of pediatric care. These services include continuous access to medical care, referrals to pediatric subspecialists and surgical specialists, interaction with early intervention programs and child care programs, early childhood education programs and schools to ensure that the special needs of the child and family are addressed."
4. U.S. Bureau of the Census. Census 2000 Summary File 1. Washington, DC, 2000.
5. See note 4, U.S. Bureau of the Census.
6. The region's commitment to high technology has given Silicon Valley the highest median income in the United States at $87,000.
7. Brown, E.R., Ponce, N., Rice, T., and Lavarreda, S.A. *The state of health insurance in California: Findings from the 2001 California Health Interview Survey.* Los Angeles, CA: UCLA Center for Health Policy Research, June 2002.
8. Wong, L. *Background data and models for expanding health insurance coverage to children in Santa Clara County.* San Carlos, CA: Institute for Health Policy Solutions, October 2000. Based on analysis of the Current Population Survey by the UCLA Center for Health Policy Research.
9. See note 4, U.S. Bureau of the Census.
10. Santa Clara Valley Health and Hospital System. *Monthly enrollment report.* Santa Clara, CA: SCVHHS, September 1, 2002.
11. See note 4, U.S. Bureau of the Census.
12. Office of Financial Management. *Washington State Population Survey.* Seattle, WA: 1998 and 2000. Although the point estimate is 8.5%, the actual percentage with 95% confidence is between 7% and 10.3%.
13. See note 4, U.S. Bureau of the Census.
14. See note 12, Office of Financial Management. Although the point estimate is 21.3%, the actual percentage with 95% confidence is between 20% and 22.6%.
15. Washington's Basic Health Plan is a state-sponsored program that provides health care coverage to low-income Washington residents through eight private health plans. Monthly premiums are based on family size, income, age, and the health plan selected. Co-payments are required for most services, but there are no deductibles or coinsurance. For those who qualify for Basic Health, state funds are used to help pay a portion of the monthly premium.
16. King County Health Action Plan. *Finding the balancing points: The changing state of health care in King County.* Seattle, WA: January 2000.
17. American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. Policy statement: The medical home. *Pediatrics* (2002) 110:184–86; see also Simpson, G., Bloom, B., Cohen, R.A., and Parsons, P.E. Access to health care, part 1: Children. *Vital Health Statistics* (1997) 196:1–46.
18. Public Health–Seattle and King County. *HRSA Community Access Program grant.* Seattle, WA: May 2001.
19. See note 18, Public Health–Seattle and King County.
20. See note 16, King County Health Action Plan. See also Susan Johnson, director, King County Health Action Plan, September 1, 2002.
21. See note 20, Johnson.
22. California voters passed the California Children and Families First Act (Proposition 10) in November 1998 to levy a 50-cent tax on every pack of cigarettes purchased in the state, as well as comparable taxes on other tobacco products. Since 1999, the nearly $700 million Proposition 10 has generated annually has been dedicated to developing and implementing programs for young children and their families across the state. To facilitate the statewide focus on early care and development, the California Children and Families First Commission (CFFC) was formed at the state level, and a CFFC was created in each of California's 58 counties.
23. Guido, M. Santa Clara County Children's Health Initiative enters partnership with Sun Microsystems employees. *San Jose Mercury News.* January 2, 2002, at Section B, Page 1B.
24. See note 20, Johnson.
25. Health-e-App is an automated Web-based application to enroll low-income children and pregnant women in public health insurance programs. Using a Web-enabled device, state-certified application assistants enroll eligible applicants in California's SCHIP and children and pregnant women in the state Medicaid program.
26. See note 8, Wong, p. 3.

Glossary of Selected Terms and Acronyms

AAP	American Academy of Pediatrics
AFDC	Aid to Families with Dependent Children
AIM	Access for Infants and Mothers Program
BBA	Balanced Budget Act
CAHPS	Consumer Assessment of Health Plans (CAHPS) is a kit of survey and reporting tools to help consumers and purchasers assess and choose a health plan. The questionnaires were developed by the Agency for Healthcare Research and Quality at the U.S. Department of Health and Human Services.
Carve Out	When services are "carved out," managed care plans are not contractually obligated to provide them. States may establish a separate, capitated system for those services, provide them in a fee-for-service system or allow beneficiaries to visit any other Medicaid provider to receive them.
CBO	community-based organization
CFFC	California Children and Families First Commission
CHAMPUS	Comprehensive Health and Medical Plan for Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans' Affairs
CHI	Santa Clara Children's Health Initiative
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
CPS	Current Population Survey
Crowd-out	Crowd-out, also known as substitution, occurs when individuals or employers drop employer-sponsored or individual private health insurance in order to enroll in a public insurance program. Title XXI requires states to include measures to prevent crowd-out.
CSHCN	Children with special health care needs (CSHCN) are those who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services that extend beyond the type and amount generally required by children. Conditions of risk may be diagnosed disorders; events that occur during prenatal, perinatal or neonatal periods; and environmental conditions, such as poverty and family stress.
DHHS	Department of Health and Human Services
DMA	Massachusetts's Medicaid agency, the Division of Medical Assistance

DPSS	Department of Public Social Services
DSHS	Department of Social and Health Services
EITC	earned income tax credit
ELE	express lane eligibility
EPSDT	Early and periodic screening, diagnosis and treatment (EPSDT) is designed to enhance primary health benefits for children under age 21. The comprehensive EPSDT package emphasizes preventive care. EPSDT is mandated for Medicaid-eligible individuals under age 21. States must provide any medically necessary service warranted by medical examination, even if the service is not included in the state's Medicaid plan.
ESI	Employer-sponsored insurance (ESI) can be used to insure children in Title XXI through the use of a family coverage variance. Children can be covered by ESI as a dependent of a parent who has health insurance through an employer. A number of stipulations and criteria apply.
FCIA	Foster Care Independence Act
FEHBP	Federal Employees Health Benefit Program
FFS	Fee-for-service (FFS) is a payment system in which health care providers, hospitals, and other providers are paid for each service performed.
FPL	The federal poverty level (FPL) and the poverty guidelines are published annually in the Federal Register.
HCFA	Health Care Financing Administration
HEDIS	The Health Plan Employer Data Information Set (HEDIS) is a standardized set of performance measures used to assess the performance of health plans in several areas, including access to care and quality of care. It is sponsored, supported and maintained by the National Committee for Quality Assurance (NCQA).
HIFA	Health Insurance Flexibility and Accountability
HIPP	Medicaid Health Insurance Premium Payment
HMO	A health maintenance organization (HMO) is an entity that contracts on a prepaid capitated risk basis to provide comprehensive health services to beneficiaries. It is a type of managed care organization.
HRSA	Health Resources and Services Administration
ICHIA	Immigrant Children's Health Improvement Act
INS	Immigration and Naturalization Service
KGC	King County Kids Get Care
Medicaid Look-Alike	A Medicaid look-alike refers to a state-designed SCHIP health benefits package that mirrors the Medicaid package.
MCCA	Medicare Catastrophic Coverage Act of 1988

MCHB	Maternal and Child Health Bureau
MCO	managed care organization
MIS	management information system
MSA	metropolitan statistical area
NSAF	National Survey of America's Families
OBRA	Omnibus Reconciliation Act
OMB	Office of Management and Budget
PCC, PCP, PCM	The primary care coordinator (PCC), primary care provider (PCP) and primary care manager (PCM) refer to the physician or care provider who serves as the initial contact between the beneficiary and the medical care system and who is responsible for coordinating the treatment of beneficiaries assigned to his or her panel.
PE	presumptive eligibility
PPO	A preferred provider organization (PPO) is a type of managed care delivery system. It contracts with health care professionals to provide services to beneficiaries at discounted rates.
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
SCHIP	The Balanced Budget Act of 1997 created Title XXI of the Social Security Act; also called the State Children's Health Insurance Program (SCHIP). SCHIP allows states to establish a state-designed program, to expand their Medicaid program, or to use a combination of these approaches to provide health insurance to low-income children. States receive an enhanced match rate for services provided to eligible children and are allowed a great deal of flexibility in the design and operation of their SCHIP.
Section 1115 Waiver	Medicaid research and demonstration waivers (also known as Section 1115 waivers) are normally used to make broad changes in eligibility, services, or the service delivery system. HCFA will consider Section 1115 waivers under SCHIP if a state has at least one year of experience providing health care assistance through SCHIP, if it has submitted all required evaluations and reports to HCFA, if the state has met the primary goals of SCHIP, and if the state has done everything allowed under SCHIP to enroll and serve eligible children. A number of other criteria apply. Guidelines for SCHIP Section 1115 waivers were released July 31, 2000.
SHCN	special health care need
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TEFRA	Tax Equity and Fiscal Responsibility Act
Title XIX	Title XIX of the Social Security Act, also known as Medicaid, was established in 1965 as a joint federal–state program. Medicaid provides medical assistance to certain families and individuals with low incomes.
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

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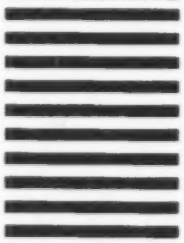

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